Confidential Developmental History

Child's Name: _____ Date: _____

Date of Birth _____ Parent(s):_____ Phone: _____

Address: _____

BASIC INFORMATION

Height: _____ Weight: _____ Hair Color: _____ Eye Color:_____

Identifying Marks: _____

Primary Language of Child: _____ Primary Language of Parents_____

BIRTH AND INFANCY

City & State of Birth: _____

Place of Birth: Home or Hospital: _____ Type of Birth: _____

Birth Weight: _____ Birth Length: _____ Breast Fed or Bottle Fed: _____ Until When:_____

What age did your child begin to: Sit _____ Crawl _____ Walk _____ Talk _____

Any speech difficulties? _____

Is there any information about your child's birth/infancy which you think would help the teacher more fully understand your child, for example, birth complications, illnesses, adoption?_____

_____

EATING HABITS

Special characteristics or difficulties, including allergies or sensitivities:

_____

_____ Slow or Fast eater_____

Favorite foods _____ Food refuses_____

TOILET HABITS

Is your child ever reluctant to use the bathroom? _____ Does your child have accidents? _____

Does your child have any special needs in this area? _____

SLEEPING HABITS

Does your child become tired or nap? _____ When does your child go to bed?_____ Rise? _____

Dreams _____ Nightmares_____ Bed Wetting_____ Uninterrupted sleep_____

Child sleeps in: Own room _____Shared room with sibling/s _____Family bed _____

FAMILY/HOME

Please list household members:

Name	Age	Relationship

How do you discipline your child? _____

_____

Please describe your child's schedule on a typical day: _____

_____

Do parents share responsibility for child's daily rhythm? _____ For child's discipline? _____

Have there been significant changes in family (death, illness, divorce/separation, moves, etc.) _____

_____

Briefly describe your attention to family traditions, rituals and celebrations: _____

_____

SOCIAL RELATIONSHIPS

If your child has had previous schooling please indicate:

Name and address of school: _____ Dates attended: _____

What kind of experience was this for your child? _____

_____

Has your child received a specialized evaluation, such as educational / psychological, hearing, speech, etc.? If so, please describe: _____

_____

Has your child received any Academic Intervention Service (AIS) or tutoring? If so, Please describe:

_____

_____

Does your child have an Individualized Education Plan (IEP)? _____

How would you describe your child? _____

_____

How is your child in a social setting with peers? _____

Your child's reaction to strangers_____ Ability to play alone_____

Favorite toys and activities _____ Fears: _____

Describe the role that media plays in your child's life:_____

_____

Hours of media exposure (TV, computer, video, electronic games, radio) daily: _____

How are you hoping school will affect your child? _____

_____

Is there anything else you would like us to know about your child? _____

_____

_____

Parent/Guardian Signature_____ Date: _____

Parent/Guardian Signature_____ Date: _____

PLEASE RETURN THIS COMPLETED FORM:
Save the file and then upload it on the AWS Portal (https://awsc.achieve-technology.us/) OR mail it to Aurora Waldorf School, 525 West Falls Rd., West Falls, NY 14170