Learn, Grow, Thrive

Family Structure and Child Development

The purpose of this questionnaire is to allow the teaching staff a better understanding of your child and your family. All information is confidential.

GENERAL INFORMATION

Child's full name________________________Nickname _______________ DOB_____________

Race/ethnicity____________________Nationality _______________ Religion_________________

Person providing this information:_____________________ Relationship to child_____________

Is child your: □ biological child □ adopted child □ foster child □ other:___________________

FAMILY STRUCTURE & LIVING SITUATION

Father's Name___________________ Occupation_______________ Highest education: ________

Mother's Name__________________ Occupation_______________ Highest education: ________

Guardian's Name_________________ Occupation_______________ Highest education: ________

With whom does child live *at least half* the time? (Check all that apply)

□ both parents in the same home □ mother's home □ father's home

□ other's home (specify) ____

List all people living in household (indicate which household if child lives in multiple homes):

Name	Age	Relationship to child	Which home? (Leave blank if N/A)

Any pets? (Indicate type, name, household)____

Language(s) spoken at home ___________________ Primary language at home _______________

List all locations (city, state, and/or country) that your child has lived:

1. Birthplace ______________________ Moved at age ______
2. ________________________________ Moved at age ______
3. ________________________________ Moved at age ______

Are parents of child currently:

□ unmarried, living together
□ married
□ separated
□ divorced
□ never married, not living together

If separated, divorced, or never married and not living together, who has *legal* custody?

□ mother □ father □ both
□ other (specify): ____________________

If separated or divorced, how do you feel your child has adjusted to separation/divorce?

____
____

Are the other adults who have a *significant* part in raising your child? □Yes □No If so, please indicate name & relationship (i.e., step-parent, grandparent, etc.) ____________________
____

SOCIAL-EMOTIONAL DEVELOPMENT

Has your child had previous experience with a fulltime babysitter/nanny, child care home/center, or other care outside your home? □Yes □No If so, when, with whom, and how often? ____________________

Have there been any significant changes in the home over the last few years? (i.e., new marriages, deaths, births, address changes, family separation/divorce, parent dating, money problems, etc.) ____________________
____

What do you feel are your child's…
Strengths____________________ Weaknesses____________________

Reaction to strangers: ____________________ Able to play alone? ____________________

How much time each day does your child typically spend on the following electronic media?
Watching TV: __________ Playing video/computer/phone games: __________ Other________

Does anyone read aloud to your child at home? □Yes □No If so, how often? __________

At what age did your child begin playing with other children? ____________________

What are your child's favorite activities? ____________________

Is your child affectionate? ____________________

Does your child celebrate holidays or special occasions? ____________________

Are there occasions in which you would rather your child not participate? ___________________

What are the things your child seems to fear? ____

Has your child had any frightening experiences? If so, describe briefly: _____________________
____

What is the method of behavior management/discipline at home? __________________________
____

HEALTH AND DEVELOPMENT

Any known complications at birth? ____

Serious illnesses and/or hospitalizations:____

Special physical conditions, disabilities: ____

Is your child currently taking any medication? □ Yes □ No If yes, please list medication and uses: ____

Has your child ever been identified as having a disability? □ Yes □ No If so, by whom, what age, & what disability? ____

Has your child ever received psychological counseling? □ Yes □ No If yes, by whom (professional/ agency) and when: ____

During your child's first few years of life, were any of the following significantly present?

- □ Difficult to comfort
- □ Was not easily calmed by being held or stroked
- □ Colicky
- □ Excessive irritability
- □ Diminished sleep
- □ Difficult nursing
- □ Poor eye contact
- □ Did not respond to their name
- □ Fascination with certain objects
- □ Constantly head banging

* If you checked any of the above, please describe______________________________________

PARENTING

Which adult would your child prefer to talk with about a problem? _________________________

Who is the family member with whom your child feels closest? ___________________________

Who is primarily responsible for discipline at home? ____________________________________

What is the most effective way to deal with your child's behavior problems at home? __________
____

How does your child respond to discipline at home? ____________________________________

List any responsibilities your child has at home: ______________________________________

Does your child do these regularly? □ Yes □ No

Does your child need frequent reminders? □ Yes □ No

SLEEPING HABITS

Indicate your child's… Bed time? ________ Wake time? _______ Do they sleep well? _______

Does your child sleep in a… Crib? ________ Bed? _______ Other? ____________

Does your child sleep *in a room* alone? □ Yes □ No If not, with whom do they share? ___
____

Does your child sleep *in a bed* alone? □ Yes □ No If not, with whom and how often? ________
____

Does your child become tired or nap during the day (include when and how long)? ____________
____

Describe any special characteristics or needs (stuffed animal, story, mood on waking, etc.) _____
____

How does your child fall asleep? (Check all that apply)

□ Rocking chair
□ Laying with someone
□ On their own
□ Other ____

EATING HABITS & NUTRITION

Is your child usually hungry at mealtime? □ Yes □ No Between meals? □ Yes □ No

Is your child able to eat with a…

Spoon? □ Yes □ No
Fork? □ Yes □ No
Hands? □ Yes □ No

At home, what time does your child eat breakfast? _______ Lunch? ___________ Dinner? _____

Favorite foods: ____

Foods refused: ____

Eating problems or difficulties: ____

List foods your child may not eat: ____

TOILETING HABITS

Has toilet learning been attempted? □ Yes □ No

How does your child indicate toileting needs (include special words): ____________________
____

Please describe any particular toileting procedure(s) to be used for your child at the center: _____
____

What is used at home?

Pottychair?	□ Yes	□ No
Special child seat?	□ Yes	□ No
Regular seat?	□ Yes	□ No

Is your child ever reluctant to use the toilet? □ Yes □ No If yes, what are the circumstances? __
____

Does your child have accidents? □ Yes □ No If yes, what are the circumstances? ________
____

Are bowel movements regular? □ Yes □ No How many per day? ___________________

Is there a problem with diarrhea? □ Yes □ No If yes, what are the circumstances? ________
____

Is there a problem with constipation? □ Yes □ No If yes, what are the circumstances? ________
____

ADDITIONAL INFORMATION

Please provide us with any additional information that will help us care for your child.