



Peer Preschool Developmental History

Please return completed form.

Date: \_\_\_\_\_

I. General Information

Child's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

Information given by: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone \_\_\_\_\_

Emails both parents \_\_\_\_\_

Brothers and Sisters: \_\_\_\_\_ Age \_\_\_\_\_

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

Please tell us what has prompted you to have your child participate in the Integrated Preschool Program?

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II. Areas of Concern

Please place a check next to any behavior or problem that this child currently exhibits and explain:

- has difficulty with speech (pronouncing sounds/words)
- has difficulty with language (putting words together)
- has difficulty following directions, listening, and attending
- has difficulty with hearing
- has difficulty with vision
- appears awkward and uncoordinated
- trips or falls often
- has difficulty with toilet training
- has sleep problems
- has eating problems (for example: chokes, gags, overstuffs, poor chewing, fussy eater)
- drooling is noticed
- has frequent tantrums
- appears more active than children his/her age
- appears tired or weak
- is impulsive
- unusually sensitive to noise or sudden movement
- is considered discipline problem at home or school
- has difficulty learning
- has difficulty playing with other children
- avoids different tactile experiences (i.e. sand, grass, water, Playdoh)

III. Medical History

1. Pregnancy and Birth (If adopted or foster, check here \_\_\_\_\_ )

Length of pregnancy: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Please check the appropriate column	Yes	No
Use of medication/drugs during pregnancy		
Received regular prenatal care		
Labor lasted longer than 12 hours		
Labor lasted less than 2 hours		
Had a caesarian section		
Other _____		

Did this child present any of the following problems at birth?	Yes	No
RH incompatibility		
Yellow or jaundiced		
Convulsions		
Cerebral Palsy		
Cleft lip or palate		
Need for oxygen		
Feeding, sucking, swallowing problems		
Blood transfusions		
Chemical dependency		
Other _____		

2. List any medications used over a long period of time:

\_\_\_\_\_

3. List any medications currently being used:

\_\_\_\_\_

4. Who is the child's current pediatrician?

\_\_\_\_\_

5. Date of most recent physical exam: \_\_\_\_\_

Please check the appropriate column	Yes	No
Allergies		
Neurologist		
Ear, nose, throat		
Orthopedist		
Speech Therapist		
Occupational Therapist		
Physical Therapist		
Ophthalmologist		
Optometrist		
Psychiatrist/psychologist		
Educator		



VI. Play Information

Please provide an explanation for any yes answer.

1. Does the child currently attend preschool?
2. Does the child regularly attend community group activities (i.e. church, library, gymnastics)?
3. Does the child routinely play with other children?
4. Do you have any concerns regarding the way your child interacts with his/her peers?
5. Do you have any concerns regarding the way your child interacts with family members (i.e. siblings, cousins)?
6. What are the child's favorite toys or activities?
7. Please add any information which you feel may help us in working with this child.