



## Big Box of Crayons Family Preschool - Child's History Form

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

### HEATH HISTORY

1. Does child seem well most of the time? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Does child frequently have ear trouble? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does child frequently have colds? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does child frequently have sore throats? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Does your child get hurt easily? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Does child have asthma? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Does your child have a sensory disorder? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Does child have any special needs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to any, please explain \_\_\_\_\_

9. Circle any of the following which apply to your child:

Eczema    Hives    Hay Fever    Wheezing    Non Food Allergies    Drug Intolerance

Describe: \_\_\_\_\_

(If child has allergies a note from the doctor needs to be on file at BBC Preschool)

### SLEEPING

1. Current sleeping schedule: Night Time: \_\_\_\_\_ to \_\_\_\_\_ Nap: \_\_\_\_\_ to \_\_\_\_\_
2. Does your child take naps at home? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does your child fall asleep easily? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does your child have night terrors? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Is the child a bed wetter? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Do you have problems with your child going to sleep at night? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Do you have any special ways of helping your child go to sleep? \_\_\_\_\_

### EATING

1. Does your child have any food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what are they \_\_\_\_\_
2. Does your child have an epi-pen? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does your child have any food intolerances? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain \_\_\_\_\_
4. What is your child's general attitude towards eating?  
\_\_\_\_\_
5. What are favorite foods? \_\_\_\_\_
6. What foods are refused? \_\_\_\_\_
7. What type of milk does your child drink at home?  
1%/2% Milk    Whole Milk    Rice Milk    Skim Milk    Soy Milk    Goat Milk

### TOILETING

1. At what age was your child toilet trained? \_\_\_\_\_
2. Can child be relied upon to indicate bathroom wishes? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Does your child need to go frequently? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Is there a diarrhea problem? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Is there a constipation problem? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Does child need pull up for naptime? Yes \_\_\_\_\_ No \_\_\_\_\_

7. Can child be trusted to wash their hands correctly? Yes \_\_\_\_\_ No \_\_\_\_\_
8. What is used at home? \_\_\_\_\_ potty chair \_\_\_\_\_ regular toilet seat
9. If child is a boy, how does he pee \_\_\_\_\_ standing up \_\_\_\_\_ sitting down

**COMMUNICATION**

1. Age child began talking \_\_\_\_\_.
2. What is the primary language spoken at home? \_\_\_\_\_.
3. Is there a secondary language also spoken? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Does child have any speech problems? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Does the child use baby talk for attention? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Does the child know Baby Sign or ASL? Yes \_\_\_\_\_ No \_\_\_\_\_ Just A Little \_\_\_\_\_

**SOCIAL RELATIONS**

1. Has your child had previous group experience? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please circle which kind: ECCE Classes \_\_\_\_\_ Preschool \_\_\_\_\_ Daycare \_\_\_\_\_ Sunday School \_\_\_\_\_
2. Please list all child care your child has had for the last two years? \_\_\_\_\_  
\_\_\_\_\_.
3. Please share what you liked and disliked about the child's prior child care. \_\_\_\_\_  
\_\_\_\_\_.
4. Are their adults that are not the child's parents living in the child's home? (if yes, please name and tell relationship) \_\_\_\_\_.
5. Is there a parent or siblings that live outside of the child's home? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_.

**EDUCATIONAL**

1. Does your child know how to count to ten without help? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Can your child sing the alphabet song without help? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Can your child correctly match & name 5 colors? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Can your child write their name on their own? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Does your child know the names of 5 shapes? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Can your child put together an 8 piece puzzle without help? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Does your child like to be read to? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Can they sit and listen to 3-4 stories at one time? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Does your child like to be involved in musically activities? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Can you child make up rhythms? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY LIFE**

1. Is the child living with: Mother/Father \_\_\_\_\_ Mother Only \_\_\_\_\_ Father Only \_\_\_\_\_ Mother/Stepfather \_\_\_\_\_  
Father/Stepmother \_\_\_\_\_ Grandparents \_\_\_\_\_ Other, explain \_\_\_\_\_
2. Is there a court custody order pertaining to the child? Yes \_\_\_\_\_ No \_\_\_\_\_  
*(A copy of custody order will be required when child begin.)*
3. Is the child adopted? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, is the child aware he/she is adopted? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Other Children in Family
- | Name  | Birthday | School Attending | Live with Child (Y/N) |
|-------|----------|------------------|-----------------------|
| _____ | _____    | _____            | _____                 |

5. Does the child have any pets? If so, what is their name and what kind of pet is it? \_\_\_\_\_  
\_\_\_\_\_.
6. What are the child's religious affiliation, if any \_\_\_\_\_.

**GENERAL**

1. What does your child like to be called? (Jennifer likes to be called Jenni) \_\_\_\_\_
2. Is your child LEFT or RIGHT handed? Or do you not know yet \_\_\_\_\_?
3. Does your child clean up when done playing with something? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you feel your child is a \_\_\_ leader or a \_\_\_ follower when playing with friends?
5. Do you feel your child is more \_\_\_ outgoing or more \_\_\_ shy, after warming up to people?
6. Does the child have a known problem with hitting or biting when upset? Yes \_\_\_ No \_\_\_  
If yes, please explain \_\_\_\_\_.
7. Is the child known to make up stories or tell half-truths? Yes \_\_\_\_\_ No \_\_\_\_\_
8. Does the child have problems with "stealing", "borrowing without asking" or putting things in their pocket during play and ends up taking them home? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Favorite things to play with are: \_\_\_\_\_  
\_\_\_\_\_.
10. Favorite activities are: \_\_\_\_\_  
\_\_\_\_\_.
11. What type of behavior displayed by your child do you consider the most difficult to deal with? \_\_\_\_\_  
\_\_\_\_\_.
12. Types of discipline most frequently used in the home are: \_\_\_\_\_  
\_\_\_\_\_.
13. How would you describe your child emotionally? \_\_\_\_\_  
\_\_\_\_\_.
14. When your child is upset about something how do they express it? (i.e. pushing, yelling, crying...etc) \_\_\_\_\_  
\_\_\_\_\_.
15. Fears (history and how child shows fears): \_\_\_\_\_  
\_\_\_\_\_.
16. How do you expect your child to benefit from the BBC program? \_\_\_\_\_  
\_\_\_\_\_.
17. What would you like BBC to focus on, if they can, with your child? \_\_\_\_\_  
\_\_\_\_\_.
18. Please tell BBC anything else about your child that may be helpful to provide the quality care you would like for your child? \_\_\_\_\_  
\_\_\_\_\_.

**The information stated above is current and adequate. I understand that it is my responsibility to notify BBC Preschool of any changes.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**