

GLENDALE COMMUNITY COLLEGE CHILD DEVELOPMENT LABORATORY SCHOOL

FAMILY AND SOCIAL HISTORY - PARENT'S REPORT

The purpose in requesting this information is to assist the Child Development staff in better understanding the unique needs of your child and in offering a secure and stimulating learning environment. All information will be held in strictest confidence.

Name of Child _____ Birth date _____ Sex _____

Cultural Origin(s) _____ Biological Child Adopted
(optional - at parent's discretion)

Current Family Situation

Parent/Guardian Name _____ Age _____
Occupation _____

- Living at home with child
- Not living at home with child, communicates with child regularly periodically rarely
- Not living at home with child, has no contact
- Deceased

Parent/Guardian Name _____ Age _____
Occupation _____

- Living at home with child
- Not living at home with child, communicates with child on regular basis
- Not living at home with child, has no contact
- Deceased

Parents are: Single parent Married Living Together Separated Divorced

If child lives with primary caregivers other than parents, please answer the following:

Primary Caregiver's Name: _____

Relationship to Child: _____ Age: _____

Other children living with the family:

Name	Birth date	Sex	Relationship to Child

Name	Birth date	Sex	Relationship to Child

Other persons living with the family:

Name	Age	Sex	Relationship to Child
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What is your child's current living situation?

House Apartment Other _____

Length of residency in current home? _____

	Yes	No	
Home has indoor play space?	<input type="checkbox"/>	<input type="checkbox"/>	
Home has outdoor play space?	<input type="checkbox"/>	<input type="checkbox"/>	
Child has own room?	<input type="checkbox"/>	<input type="checkbox"/>	
Child shares room?	<input type="checkbox"/>	<input type="checkbox"/>	With whom? _____
Does family have pets?	<input type="checkbox"/>	<input type="checkbox"/>	
What kind of pets?	_____		

Physical Health

Birth weight _____ Condition at birth _____

Walked at _____ months. Began talking at _____ months.

Other languages spoken in the home _____

Toilet independence started at _____ months.

What health problems has your child had in the past? _____

What health problems does your child have now? _____

Does your child have any allergies? If so, to what? _____

Does your child take any medicine regularly? If so, what? _____

Has a disability been diagnosed? _____

Does the child have:

	Yes	No		Mild	Severe
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>
frequent earaches	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>
frequent coughs	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>
frequent stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>
frequent nosebleeds?	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>
frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	If "yes"	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any concerns about your child's health _____

What arrangements can you make for child's care during illness?

Social History

Has the child been to preschool? _____ Where? _____ How long? _____

Has the child had group play experience? _____

What ages are you child's most frequent playmates? _____

Does your child need time or preparation to change from one activity to another? _____

Who does the most disciplining in the home? _____

What works best when you discipline your child? _____

How does the child react to discipline? _____

How do you comfort your child? _____

Daily Routine History

What time does child get up? _____ Go to bed? _____

Yes No

Does child sleep during the day?

When? _____

How long? _____

Does child sleep well?

Nightmares?

Eating hours: Morning meal _____ Noon meal _____ Evening meal

Is your child usually hungry at mealtime?

Between Meals?

Food aversions _____

Favorite foods _____

Any foods you do not want your child to eat _____

Eating problems: _____

Toilet Habits:

Yes No

Regular bowel movements?

Usual time(s)? _____

Is child frightened of the bathroom?

Does child need assistance with toileting?

Has your child been circumcised?

In what way does the child need assistance? _____

Does the child have toileting accidents?

When do they normally occur? _____

What is the child's reaction? _____

Word used for bowel movement? _____ Urination _____

How does child indicate when to use the bathroom? _____

Additional comments that would assist us in understanding your child and his/her needs:
