

GENERAL HEALTH

1. Does your child have any special physical conditions or disabilities?

2. Any serious illnesses and/or hospitalizations? _____

3. Does child take any medications regularly? _____

4. Has your child ever complained about headaches? _____

5. Does your child follow directions? _____

6. Does your child have any allergies? _____

7. Does your child have asthma? _____ If yes, what do you do to treat it? _____

SCHOOL HISTORY

1. Has your child been in day care or school? _____ If yes, what school has your child attended?
_____ Which grades? _____ How was the
experience? _____

2. Has your child been recommended for an evaluation? Y ___ N ___ If yes, what kind of evaluation has
been recommended? physical _____ psychological _____

3. Does your child have any learning issues that you are aware of? _____
Describe the situation _____

4. Does your child receive special services? _____

PARENT INFORMATION

1. How do you discipline your child? _____

2. How do you comfort your child? _____

3. Does your child have any specific fears? _____

4. How does your child show his/her anger? _____

5. What time does your child go to bed? Wake up? _____

6. How much television does your child watch each day/week? _____

7. Is there a television in your child's bedroom? _____

8. Is there anything else you would like us to know about your child that would help us to teach him/her in
the best way?
