Virginia Marx
Children's Center
at Westchester Community College

Preschooler Intake Form

Child's Name: _____ Nickname: _____

Date of Birth: _____ Gender: M___ F___

Parents Name: _____

Family History

Who lives in the child's home? (Include names and ages of siblings)

_____

Who is the child's primary caretaker? _____

Other family members involved: _____

Sibling's reaction to child's birth: _____

Any recent changes on your family's situation: _____

_____

Age at which child first left with caretaker: _____

Language(s) other than English regularly spoken at home: _____

Are there any family traditions/cultural practices that you would like us to be aware of to make your child more comfortable?

_____

_____

School History (include preschool, day care, nursery school, Head Start)

Has your child attended school before, if so for how long?

_____

Child's Medical History

Pregnancy/birth – normal/full term?_____

Does your child have a history of the following?

Frequent colds: _____ Frequent diarrhea:_____ Asthma:_____ Nosebleeds:_____

Ear Infections: _____ Stomach Aches:_____ Seizures:_____ Headaches:_____

Urinary Infections:_____

Please indicate what brings on the above conditions if you know:

_____

_____

What illness (es) has your child had and at what age?

Chicken Pox:_____ Scarlet Fever:_____ Mumps:_____ Measles:_____

Other: _____

Does your child have?

Hepatitis: _____ Diabetes:_____

Does your child vomit easily?_____

Does your child run high fevers often?_____

Has your child had any serious accidents? If so please explain:

_____

_____

Does your child have any allergies?

_____

_____

If so, how are they manifested?

Asthma: _____ Hay Fever:_____ Hives:_____ Other:_____

_____

Does your child have any FOOD allergies?

_____

_____

Does your child receive any medication regularly?

_____

_____

Do you have any concerns in these areas?

Speech:_____ Physical:_____ Hearing:_____ Vision:_____

Child's Development

	YES	NO	DON'T KNOW
1. Can your child:			
a. Use a spoon and fork to eat without spilling a lot?	_____	_____	_____
b. Wash and dry his/her own hands?	_____	_____	_____
c. Dress him/her self?	_____	_____	_____
d. Do buttons?	_____	_____	_____
e. Be left alone with a babysitter without a big fuss?	_____	_____	_____
2. Does your child have?			
a. Problems with eating?	_____	_____	_____
b. Problems with sleeping	_____	_____	_____
3. Does your child soil his/her pants?	_____	_____	_____
4. Does your child:			
a. Play successfully with puzzles, blocks and other construction toys without help?	_____	_____	_____
b. Hold a crayon/pencil properly?	_____	_____	_____
c. Write and draw rather than scribble?	_____	_____	_____

Does your child prefer their right, left, or both hands? _____

General

What adjectives best describe your child?

_____

_____

How would you describe your child's personality?

_____

_____

How does your child respond to other children?

_____

_____

Has your child had any other group play experiences?

_____

_____

How does your child cope with separation?

_____

_____

What characterizes your child's behavior when upset, angry or afraid?

_____

_____

Does your child have any specific fears?

_____

_____

What helps your child regain balance?

_____

_____

Do you have any special concerns about your child's development?

_____

_____

Is there any other information our staff should be aware of to better care for your child?

_____

_____

_____

_____

_____

_____

Parent Name (please print) _____

Parent Signature _____

Date _____