CHILD and FAMILY INFORMATION FORM

Today's Date _____

Child's Name _____ Date of Birth _____

Sex F M

Who is completing this questionnaire? _____ Relationship to Child

_____

Child's Ethnicity _____ Language Child Speaks _____

Other languages child speaks or hears _____ School District & Neighborhood School _____

Languages mother speaks _____ Languages father speaks _____

Please list any educational, daycare, extracurricular, or therapy programs that your child has recently attended or attends:

Name of Program:	Name of Persons in Charge:	Date of Last Enrollment /Appointment:
_____	_____	_____
_____	_____	_____

Has your child ever had an IEP or IFSP with any school district or agency? If so, with whom? _____

Child's Caseworker, if applicable _____ Phone number _____

How did you hear about our program? _____ What is your main concern, if any?_____

_____

_____

Mother's Name _____ Date of Birth _____

Mailing Address _____ (Rd, St, etc.) Apt / Unit: _____

City: _____ Zip code _____

Day Phone _____ Cell Phone _____ Home Phone _____

Occupation _____ Employer _____ Work Phone _____

E-mail _____ Permission to contact me by e-mail Yes No

Father's Name _____ Date of Birth _____

Mailing Address _____ (Rd, St, etc.) Apt / Unit: _____

City: _____ Zip code _____

Day Phone _____ Cell Phone _____ Home Phone _____

Occupation _____ Employer _____ Work Phone _____

E-mail _____ Permission to contact me by e-mail Yes No

Child lives with (please circle):

Biological Mother Biological Father Adoptive Mother Adoptive Father

Step Mother Step Father Foster Mother Foster Father

Parent's Marital Status: _____ Do you share custody? Yes No

Please list child's brothers, sisters and any other persons living in the home:

Name _____ Age _____ Relationship _____

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Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Please list recent or upcoming changes (i.e. recent move, new baby, death of a grandparent):

_____

_____

_____

_____

We apply for grants that often require information about the income and educational level of our families. The following questions are OPTIONAL and CONFIDENTIAL, but we greatly appreciate you sharing this information for grant purposes.

Mother's level of education:

___ Completed 8th grade

___ Graduated from high school

Father's level of education:

___ Completed 8th grade

___ Graduated from high school

___ Completed___ years of college/professional school
___ Completed a bachelor's degree
___ Completed a master's degree grade
___ Completed a Ph.D., MD, etc.

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___ Completed a bachelor's degree
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Family Income

___ Less than 10,000 ___ 10,000 to 19,000 ___ 20,000 to 29,000 ___ 30,000 to 39,000 ___ 40,000 to 49,000
___ 50,000 to 59,000 ___ 60,000 to 69,000 ___ 70,000 to 79,000 ___ 80,000 to 89,000 ___ 90,000 or above

BIRTH HISTORY

MOTHER'S PREGNANCY:

This child was the mother's (circle one): 1st 2nd 3rd 4th 5th 6th (or more)

Mother's age during this pregnancy _____ Any previous pregnancies not carried to term? Yes No

What were mother's medical problems before pregnancy? _____

How many people smoked in the household during pregnancy? _____

How many people currently smoke in the child's household? _____

When the mother was pregnant with this child, did she:

Yes No Have bleeding or spotting
Yes No Have high blood pressure
Yes No Have Measles, Mumps, Chicken Pox
Yes No Have Toxemia, Anemia, Cytomegalovirus
Yes No Take prescription drugs _____
Yes No Consume alcohol
Yes No Smoke
Yes No Have any accidents or injuries
Yes No Have any other problems _____

Yes No Did mother go into labor by herself
Yes No Did labor last longer than 24 hours
Yes No The baby came out by itself
Yes No Forceps were used during delivery
Yes No Baby was head first
Yes No Baby was cesarean delivery
Yes No Baby was delivered in hospital
Yes No Mother saw a doctor within 1st 2 months of pregnancy

BIRTH HISTORY:

Yes No Was your child premature? _____ weeks
Yes No Baby cried at birth
Yes No Baby stayed longer in hospital than mother
Yes No Baby had difficulty sucking and feeding
Yes No Oxygen was required at birth
Yes No Rh Factor was involved
Yes No Mother was given drugs at birth

Birth Weight _____
Birth Length _____
Concerns at birth _____
_____
_____

APGAR scores, if known _____

During the hospital stay did your baby have:

Yes No Yellow jaundice
Yes No Blue spells
Yes No Seizures
Yes No To stay in an incubator
Yes No Any type of surgery

Has your child been followed by any newborn follow-up programs? Yes No
Program name/s: _____
_____
_____

FAMILY HISTORY:

Are there any twins or multiple births in the child's family? Yes No If so, what is their relationship to this child (e. g. brother, cousin, grandfather, etc.): _____

Do any family members (siblings, cousins, aunts, uncles, etc.) have:			Their relationship to your child:
Yes	No	Speech Problems or Delays	_____
Yes	No	Language Problems or Delays	_____
Yes	No	Stutter or Stammer	_____
Yes	No	Receive Special Education Services in school	_____
Yes	No	Developmental Delays (e. g. Down Syndrome, Autism)	_____
Yes	No	Learning Disabilities	_____
Yes	No	Attention Deficit	_____

Yes	No	Hyperactivity	_____
Yes	No	Left Handedness	_____
Yes	No	Chronic Illness	_____
Yes	No	Birth Defect	_____
Yes	No	Other disability or special need	_____

CHILD'S MEDICAL HISTORY

Who is your child's primary care physician? _____

What type of medical coverage do you have for your child? _____

Pease list any medications your child takes regularly:

Medication _____ Frequency _____ Purpose _____

Medication _____ Frequency _____ Purpose _____

Has your child ever stayed in a hospital overnight? If so, please explain _____

_____

The following questions pertain to your child at any time since birth:

EYES

Y N Has your child ever had trouble seeing?
Y N Has your child had a vision exam?
Date:_____
Dr. Name:_____

EARS

Y N Has your child ever had trouble hearing?
Y N Has your child had frequent ear infections?
Y N Has your child had an audiological exam?
Date:_____
Dr. Name: _____

NEUROLOGICAL

Y N Does your child have seizures? Date of last seizure: _____ Dr. Name: _____

Y N Has your child been evaluated by a Neurologist? Date:_____ Dr. Name: _____

Findings: _____

NOSE

THROAT

Y N Has your child had frequent nosebleeds?
Y N Does your child have allergies?
List allergies: _____

Y N Has your child had difficulty swallowing?
Y N Does your child have frequent sore throats?
Y N Have Tonsils or Adenoids been removed?
Date: _____

LUNGS

Y N Has your child ever been exposed to Tuberculosis?
Y N Does your child have Asthma?

HEART

Y N Has a heart condition ever been diagnosed?
Dr. Name: _____
Explain: _____

ABDOMEN

Y N Does your child have frequent diarrhea?
Y N Does your child have frequent constipation?
Y N Is your child potty trained for bowel movements?

URINARY TRACT

Y N Is your child potty trained for urination?
Y N Does your child have a history of kidney? or bladder infections?

EXTREMITIES

Y N Has your child ever broken a bone?
Explain: _____

Y N Has your child ever worn braces or corrective shoes?
Y N Does your child have any weakness in arms or legs?

CHILDHOOD DISEASES

Has your child had any of these diseases or allergies?

Y N Measles	Y N Mumps	Y N Chicken Pox	Y N Roseola
Y N Whooping Cough	Y N Polio	Y N German Measles	Y N Asthma
Y N Hepatitis	Y N Eczema	Y N Wheezing	Y N Rashes

Additional Notes: _____

_____

CHILD'S DEVELOPMENT

What self-help skills does your child consistently demonstrate at home (for example: buttoning, dressing, combs hair)? _____

_____

_____

What hand does your child prefer? Right Left Both

At about what age did your child: Sit alone? _____ Walk? _____ Say single words? _____

Begin to speak in sentences? _____ Become toilet trained? _____

Please check if your child has difficulty with any of the following:

____sleeping	____tripping or running into things	____eating	____concentrating
_____ paying attention	____playing with other children	____shyness	____aggression

____mood swings ____separating from parents ____cries easily ____calming down

____afraid to speak ____becoming overly excited ____ talking so that he/she is understood

____ toileting accidents

How does your child learn best? _____

_____

_____

_____

What motivates your child? _____

_____

_____

_____

What are your child's favorite toys and activities? _____

_____

_____

_____

What stands out about your child's temperament and personality? _____

_____

_____

_____

_____

Describe any recent changes in your child's speech or language development: _____

_____

_____

_____

_____

How many words does your child usually say in a sentence? _____

Please write an example of two sentences your child might say: _____

_____

_____

_____

How do you discipline your child: _____

What are the three most important things you would like your child to experience and / or learn at Wings on Words:

Additional information you would like us to know: