

Toddler Development Form

Child's Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Gender: _____ Date this form completed: _____

Please tell us about your child's physical development.

Birth Information

- Term
- Premature (_____ weeks)
- Adopted
- Trauma at birth
- Early illness or medical complications

If you checked "Trauma at birth" or "Early illness or medical complications," please describe:

At what age did your child start crawling? _____ months

At what age did your child start walking? _____ months

Does your child put objects in their mouth? Yes No

My child wears Diapers Pull-ups Underwear

Describe your child's toilet training:

Describe your child's eating habits (e.g., any special dietary needs, picky eater, avoids certain textures, etc.):

Does your child feed themselves?

- Yes No Sometimes

What are your child's sleeping habits? Mark all that apply.

- Falls asleep easily
- Falls asleep with difficulty
- Difficulty waking
- Difficulty sleeping through the night

Describe your child's current napping routine:

Does your child fall asleep on their own?

- Yes No Sometimes

Check any medical conditions that pertain to your child:

- Allergies Ear Infections Seizures
- Asthma Eye Problems Stomachaches

If you checked any of the above, please describe:

If your child takes daily medication, please describe:

Has your child ever had an accident that caused unconsciousness?

- Yes No

Has your child had any other medical conditions or incidents?

- Yes No

If you checked "Yes" to either of the above, please describe:

For children 24-36 months:

Does your child walk up and down stairs using the handrail?

- Yes No

Does your child jump with feet together lifting both feet off the ground?

- Yes No

Please tell us about your child's behavior.

Do you have any concerns about your child's behavior (e.g., cries a lot, frightened easily, activity level, particular behaviors, etc.)?

When frustrated, does your child:

- Give up Get mad Ask for help Other

If you checked "Other," please describe:

How does your child approach new experiences?

- Easily Cautiously Anxiously

If your child has any fears, please describe:

Does your child carry a security item? If so, please describe:

Please check any of the following that describe your child:

- Gets along better with older children
- Enjoys repeating a familiar task often
- Stays busy with self-directed activities
- Gets along better with younger children
- Enjoys watching others do tasks
- Enjoys being challenged by difficult tasks

What activities does your child enjoy?

How often is your child around other children their own age?

Who, besides yourself, is entrusted with the care of your child?

Is your child sensitive to or distracted by:

- Touch (e.g., your child is bothered by wet clothes or when hands are wet and dirty)

- Sound (e.g., your child is bothered by loud noises like the vacuum cleaner, shouting, loud music, etc.)

What is your child's reaction when exposed to groups (e.g., parties, crowded places, etc.)?

Is your child involved in any activities outside of school?
Please describe:

Where will your child spend non-school hours?

Please tell us about your child's language development.

At what age did your child start naming objects?

_____ months

At what age did your child start forming sentences?

_____ months

Does your child speak:

- A lot Occasionally Rarely Never

Approximately how many words does your child use?

_____ words

Can you easily understand your child's speech?

- Yes No

Can other adults easily understand your child's speech?

- Yes No

Do you have any concerns about your child's speech?

- Yes No

If you checked "Yes," please describe:

What is your child's primary language? _____

If not English, does your child understand English?

- Not at all Some words Understands very well

To communicate needs and wants, what is your child most likely to use:

- Gestures Words Phrases Crying
 Sign language

Please tell us about your parenting style.

Has your child ever been with a babysitter or in group care away from you?

- Yes No

If you checked "Yes," please describe: _____

If applicable, how does your child behave with siblings?

What do you find to be the most effective form of discipline for your child?

Please list any discipline issues your child may be experiencing:

How is the issue being handled?

How much screen time is your child exposed to (e.g., watching television, computers, or hand-held devices)?

How much time does your child spend outside?
