

ROXBURY DAY CARE CENTER, INC.

Developmental History

Name of child _____ Birthdate _____ Sex _____

Address _____ Telephone _____
 _____.

Family Members:

Mother: Birthdate _____	Father: Birthdate _____
Occupation _____	Occupation _____
Education _____	Education _____
Health _____	Health _____

(Please note any physical or mental disability.)

Parents: Living together _____ separated _____ divorced _____ deceased _____

Siblings:

Name	Age	Sex	Grade	Lives at home? (Y/N)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Others living in the home: _____

Languages spoken in the home: _____

Family history of genetic or developmental disorders? _____

Does the child have any known allergies? _____

Please circle the correct answer. If uncertain, answer with a question mark.

1. While mother was pregnant with the child, did she have any difficulties: (bleeding, anemia, diabetes, toxemia, infections, rubella, emotional stress, medications)?.....NO YES
2. Did she go to a physician or clinic regularly during her pregnancy?.....NO YES
3. Was the baby born within 2 weeks of the expected date?.....NO YES
4. How much did the baby weigh at birth? _____
5. Were there any problems during the labor or delivery?.....NO YES
6. Was there anything wrong with the baby at birth?.....NO YES
7. Did the baby have any trouble in the newborn nursery?.....NO YES
8. Did your baby come home from the hospital with the mother?.....NO YES

9. Have you consulted with a physician concerning your infant's diet? NO YES