

**SLEEPING HABITS:**

When is bedtime? \_\_\_\_\_ Wake up? \_\_\_\_\_ Does your child nap? \_\_\_\_\_ Nap time: \_\_\_\_\_  
What does he/she usually take to bed with him/her? \_\_\_\_\_  
What is his/her mood upon awakening? \_\_\_\_\_  
Does he/she have his/her own room? \_\_\_\_\_ Own bed? \_\_\_\_\_ Still Sleeps in Crib? \_\_\_\_\_  
Does he/she walk, talk or cry during sleep? \_\_\_\_\_ Please describe: \_\_\_\_\_

**SOCIAL RELATIONSHIPS:**

Has your child had any experience playing with other children? \_\_\_\_\_  
How does he/she get along with siblings? \_\_\_\_\_  
Does your child prefer to play with children his/her own age? \_\_\_\_\_  
Does he/she know any other children in the academy? \_\_\_\_\_  
How does he/she relate to unfamiliar adults? \_\_\_\_\_  
Does your child demand a lot of adult attention? \_\_\_\_\_  
What makes him/her mad or upset? \_\_\_\_\_  
How does your child show feelings? \_\_\_\_\_  
What do you find is the best way of comforting your child? \_\_\_\_\_  
What methods of discipline are used at home? \_\_\_\_\_  
What type of physical activities does your child enjoy? \_\_\_\_\_

Is your child frightened of any of the following?  
\_\_\_ Animals  
\_\_\_ Unfamiliar adults  
\_\_\_ Other children  
\_\_\_ Loud noises  
\_\_\_ The dark  
\_\_\_ Storms  
\_\_\_ Insects/bees  
\_\_\_ Other: \_\_\_\_\_

What activities does your child enjoy?  
\_\_\_ Being read to  
\_\_\_ Listening to music  
\_\_\_ Playing outdoors  
\_\_\_ Building with blocks  
\_\_\_ Painting/drawing  
\_\_\_ Puzzles  
\_\_\_ Clay/dough  
\_\_\_ Other: \_\_\_\_\_

Please check the activities your child has experienced:  
\_\_\_ Riding a tricycle  
\_\_\_ Using scissors  
\_\_\_ Finger painting  
\_\_\_ Water play  
\_\_\_ Cooking  
\_\_\_ Gardening  
\_\_\_ Riding a bus

Please check the traits that describe your child:  
\_\_\_ Active  
\_\_\_ Shy/quiet  
\_\_\_ Outgoing  
\_\_\_ Sensitive  
\_\_\_ Intense  
\_\_\_ Persistent  
\_\_\_ Adaptable  
\_\_\_ Content

**COMMENTS:**

Briefly describe your child's personality and abilities: \_\_\_\_\_  
\_\_\_\_\_

In what ways can we help your child with activities that cause difficulty? \_\_\_\_\_  
\_\_\_\_\_

What equipment and/or routines will be helpful to your child? \_\_\_\_\_  
\_\_\_\_\_

Does your child have any medical concerns we should be aware of (allergies to bees, asthma, etc)? \_\_\_\_\_  
\_\_\_\_\_

**THANK YOU FOR SHARING THIS HELPFUL INFORMATION WITH US SO WE CAN BETTER UNDERSTAND THE INDIVIDUALITY OF YOUR CHILD.**

**SIGNATURES:**

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_  
Director: \_\_\_\_\_ Date: \_\_\_\_\_ Updated: \_\_\_\_\_ Updated: \_\_\_\_\_