Buncombe Street United Methodist Church Child Development Center
200 Buncombe Street | Greenville, SC 29601
Church Office (864) 232-7341
(864) 233-5050 | fax: (864) 242-4478 | www.bsumc-cdc.com

Since 1834

Developmental History

Child's Full Name: ____ Date: ______________
Preferred or Nickname: ____________________________ Birth Date: __________________

1. DEVELOPMENTAL HISTORY

Walked At ______ Began Talking At _____ Toilet Training Began at ____ Months

2. HEALTH HISTORY

Physician's Name: ________________________________ Phone Number: ________________
Physician's Address: ____
Please list any severe illnesses, serious accidents or common childhood illnesses your child may have experienced ____
____

Any physical disabilities ____
Any know allergies or asthma ____
Any medications given regularly ____
Subject to frequent colds/ear infections ____
Is your child covered by health insurance ____
Insurance Company _______________________ Insurance Record Number ______________

3. FAMILY MEMBERS

Siblings (in order of age)

Name Relationship DOB

____
____
____
____
____

Others living in home:

____
____
____

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4. SOCIAL HISTORY

Languages spoken in the home: ____
Does your child need a favorite item (blanket, toy etc.) _______________________________
Had your child been in group-care or in situations with other children ____________________
Describe your child's personality and temperament _________________________________
____
Does your child use a pacifier _______________ Suck their thumb/fingers ______________
Are there any special ways that we can help your child _______________________________
____
Is there anything else we should know ____
____

5. EATING HABITS

Describe your child's eating style (good/picky/slow/frequency) _________________________
Favorite foods ____
FOOD ALLERGIES ____
Does your child eat with fingers, fork and spoon, etc ________________________________

6. TOILET HABITS

Special words spoken in your home for toilet or other special needs _____________________
Can your child be relied on to indicate his/her bathroom needs _________________________
What word is used for urination _________________ Bowel movement _______________
Describe any problems with diarrhea ____
Constipation ____

7. SLEEPING HABITS

Does your child take naps _____________ When ________________________________
Are there any sleeping problems ____
Does your child sleep with a favorite toy _____ What toy ___________________________

8. INFANTS-ADDITIONAL INFORMATION

Does your child have history of colic ______________ Sensitive Skin ____________________
Frequent Diaper Rash __________ List any lotion or oil used ___________________________
Any special feeding problems ____
How has child been fed (formula/breast/baby food) ___________________________________
What formula is your baby on ____
Please list a sleeping and feeding schedule on the back of this form.