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.