Hudson Country Montessori School
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INFANT/TODDLER INTAKE FORM

Child's Name: ______________________________________ Date of Birth: _______________

Parent 1 Name: ____________________ Daytime Phone #: _____________________________

Parent 2 Name: ____________________ Daytime Phone #: _____________________________

Siblings Names and Ages:
____
____

Other Members living in the household:
____
____

Do you have any pets? If so, what are their names?
____
____

What is your child's primary language? ____

Secondary language? ____

Do you have any concerns about your child's language development?
____

How frequently do you change your child?
____

How often does your child have a bowel movement? ___________________

Appearance of bowel movement: Firm Loose Constipated Diarrhea

What state is your child in for toilet training? No interest Some interest In training

Is your child toilet trained? Yes No

What are your child's words for toileting?
____
____
____

How many hours does your child sleep at night?
____

How long/often does your child nap? ______________________________

Does your child sleep with: Pacifier Blanket Toy Bottle

What comforts your child at nap time? Explain:

____

____

Explain times used (crying, nap time, etc.):

____

____

Does your child drink from a sippy or regular cup? (Please circle)

What stage is your child at in eating development? Nursing/Bottle Spoon Fed Self Feeds

Does your child eat breakfast? Yes No

Favorite foods:

____

____

____

CHILD CARE HISTORY

How many caregivers has your child had since birth?

____

____

Please explain: (length of time, etc.)

____

____

Was this care a positive experience for you and your child? Yes No
Please comment:

____

____

MEDICAL HISTORY

BIRTH

Was your child premature? Yes No

Was the pregnancy/delivery normal? Yes No
If no, Explain:

____

SINCE BIRTH

Does your child seem well most of the time? Yes No

Have your child's eyes ever looked crossed? Yes No

Does your child have frequent ear infections? Yes No

If so, how many?

Does your child have ear tubes? Yes No

Explain any special precautions we must take?

Does your child have any suspected or known special needs/ handicaps?

Yes No

Please describe:

Has your child experienced any of the following?

Surgery Yes No

Explain:

Emotional Trauma (Other than what is listed above) Yes No

Explain:

Is your child given any medication regularly? Yes No

List:

Is there anything else pertaining to your child's health that you wish to share with us?

PATTERNS/HABITS

What are your child’s favorite toys?

____

____

What are your child’s favorite activities?

____

____

Is your child exposed to other children on a constant basis? Yes No

Explain:

____

____

How do you enjoy spending time with your child?

____

____

____

____

What discipline methods are used?

______Talk to the child about what is unacceptable and what needs to be done.
_______Say “NO”
_______Spank
_______“Time Out” for _____ time/minutes
______ Have child separated from others
_______ Re-Direct

Other discipline methods used in family, please explain:

____

____

____

Does your child have any particular fears (i.e. fear of animals, etc.):

____

____

Is your child:

Highly active?	Yes	No
Cautious?	Yes	No
Generally happy?	Yes	No
Shy?	Yes	No
Very quiet?	Yes	No

Does your child:

Cry often?	Yes	No
Have temper tantrums?	Yes	No

Describe your child's personality:

___
___
___
___

Has your child recently experienced, or is your child about to experience, a major life change? For example:

Birth of a sibling?	Yes	No
Death of someone close?	Yes	No
Move to a new home?	Yes	No
Separation or Divorce?	Yes	No
New pet or loss of pet?	Yes	No
Move to a new bedroom or from crib to bed?	Yes	No

If yes, please explain:

___
___
___
___
___

We would appreciate any additional information concerning your child that might better help us to understand his/her "world":

___
___
___
___
___
___