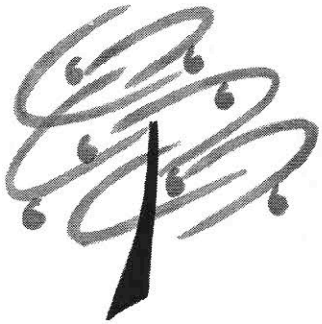

Child Profile

Please fill out the following information to help us know your child better.
NAME OF CHILD_____NAME CHILD IS CALLED_____
AGE_____DATE OF BIRTH_____
MEMBERS OF THE HOUSEHOLD:

NAME	RELATIONSHIP TO CHILD	AGE

Are there any unusual circumstances in the family which you might feel might influence your child's behavior at this time?_____ If so, please explain_____

DEVELOPMENTAL HISTORY OF CHILD

Age at which child: sat alone_____ crawled _____walked_____
slept through the night _____
named simple objects _____
repeated short sentences _____
began toilet training_____
independent toilet training _____

Does he/she dress himself/herself? _____ Undress himself/herself? _____
Is he/she right or left handed? _____

BEHAVIOR HABITS

Does he/she follow a daily routine? _____
How does he/she react to a change in routine? _____
What time does he/she usually eat breakfast? _____ Lunch? _____ Dinner? _____
Food dislikes _____
Favorites foods _____
What is typical meal time behavior? _____
Does he/she feed himself/herself? _____
Dietary restrictions: _____
Does he/she take a nap? _____
What time does he/she go to bed at night? _____ Awaken? _____
Does he/she sleep well? _____
Does he/she have any significant fears ? (Please list, i.e., thunder, clowns, dogs, etc…) _____
If so, how are you dealing with them? _____
Does he/she have difficulty separating? _____
What causes him/her to get a temper (anger)? _____
How does he/she display that temper? _____

What method of behavioral control is used in your home?_____

_____

Primary language spoken at home _____

Is child cared for routinely by individuals other than parents? _____ Does this person speak English? _____

Does he/she have an important security object? _____

How is he/she comforted by you when upset? _____

Does he/she have imaginary playmates ? _____

HEATH HISTORY

Does the child have frequent colds? _____

Does he/she have a tendency to run high fevers? _____

Has he/she had any serious accidents ? _____

_____

Is he/she allergic? _____ If so, how does it manifest itself?

Asthma?_____ Hay Fever _____ Hives _____ Skin_____

Other (explain) _____

What is the allergy caused by? _____

Does he/she have difficulty in: Speech _____ Hearing _____Vision _____

Does he/she have any other problems that we should be aware of? _____

_____

Has he/she seen a dentist? _____

Has he/she had vision testing? _____Hearing testing_____

How would you describe your child's health condition? _____

_____

_____

_____ _____

Signature of Legal Parent/Guardian Date

Please use the bottom half of this page to describe any information that you feel would be necessary for the proper care of your child.