David's Christian Learning Center
Getting to Know Your Toddler

Child's Name: ______________________________ Nickname: ____________

Child's birth date: ______________________ Sex: M F Start Date: ____________

Socialization

Has your child had previous group experience? Yes _______ No _______

If yes, please describe: ____

How does your child get along with other children? ______________________________

Circle the social approaches that describe your child: Shy Friendly Cautious Outgoing

How much does your child need in managing routines, such as dressing, toileting and eating?

____

If your child has any fears, please describe: ________________________________

____

Communication

Does your child understand directions given? Yes _______ No _______

Does your child speak to adults? Yes _______ No _______

Does you child use short phrases or sentences? Yes _______ No _______

Does your child use non-verbal gestures? Yes _______ No _______

Please elaborate on any of the above as needed: ______________________________

____

____

Emotional Behavior

Does your child like to be held when upset? Yes _______ No _______

Does your child cry easily? Yes _______ No _______

Does your child have difficulty separating from parents? Yes _______ No _______

What behaviors do you consider most difficult to deal with? _________________________

____

What type of discipline(s) do you use at home? By Mom: ________________________

By Dad: ________________________

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Sleeping Habits

What is your toddlers bedtime? _____________(PM) What time does he/she wake: ___________(AM)

Does your toddler take naps regularly? Yes _____ No ______ If yes, length: _______________

Is your child a light/Heavy sleeper? Light ___________ Heavy __________

Does your child use a security object to fall asleep? Blanket Stuffed Animal/Doll Pacifier

Does you have any special ways of helping your infant fall asleep? Yes _____ No ______

If yes, please describe: ____

Eating Habits

Is your child able to use silverware? Yes __________ No ________

Does your child need a bib when eating? Yes __________ No ________

Is your child able to wash his/her hands/face? Yes __________ No ________

What time does your child usually eat? (B) __________ AM (L) __________ AM / PM

Does your child have any food allergies/sensitivities? Yes __________ No ________

If yes, describe: ____

Favorite Foods: ____

Least Favorite Foods: ____

Any additional information you would like to share regarding your child's eating habits?

____

Diapering/Toilet Training

Frequency of diaper changes? ____

Does your child have any reoccurring rashes or other problems? Yes _____ No ______

If yes, please describe: ____

Words used at home for urination or bowel movements: ____

When does your child use the toilet? Doesn't _______Urinating ______ Bowel Movements ________

If a boy, does your child sit or stand when urinating? Yes _____ No ______

What routines are followed for regular toileting? ____

Does your child need to be reminded? Yes _____ No ______

Does your child need help re-dressing after toileting? Yes _____ No ______

Does your child sleep with a diaper/pull-up? Yes _____ No ______

If no, Does your child typically stay dry during naps? Yes _____ No ______