

# The Episcopal Day School of Evergreen

## DEVELOPMENTAL HISTORY

Child's name: \_\_\_\_\_

Age at which:

Crept on hands and knees _____	Sat alone _____
Walked unassisted _____	Named simple objects _____
Repeated short sentences _____	Slept through the night _____
Began toilet training _____	Is toilet training _____
Does child dress self _____	Right handed or left handed _____

Any speech concerns?

\_\_\_\_\_  
\_\_\_\_\_

Are there any eating problems or dietary restrictions?

\_\_\_\_\_  
\_\_\_\_\_

Nervous symptoms or habits:

\_\_\_\_\_  
\_\_\_\_\_

What time does your child go to bed at night \_\_\_\_\_

Wake up in the morning \_\_\_\_\_

Describe any special characteristics or needs to sleep (story, favorite blanket, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_