Five Seasons
Learning Centers

SCHOOL AGE INTAKE

Identification Information

Child's Name _____ BirthDate _____Sex____

If the child does not use his/her legal first name, please list the name he/she will be using_____.

Family History

Marital Status of Parents (Voluntary Information) _____

Other Children in the Home (Name and Birth Date)

1._____ 2._____

3._____ 4._____

Physical Regime

Does your child have any unusual eating problems or food dislikes?

_____

What is your child's usual bed time?_____

What is your child's usual waking time? _____

Play and Sociality

How does he/she get along with children? _____

Has he/she had previous day care experience?_____

Does your child enjoy initiating activities on his/her own or prefer more structured group experiences?

_____

Does your child have chores or responsibilities at home?

_____

What are your child's interests and hobbies? _____

Personality and Emotional Development

Does he/she accept new people easily?_____

What makes your child anxious or apprehensive?

_____

Is he/she usually happy?_____

What nervous habits does he/she have?_____

When does he/she show them? _____

When you find it necessary to discipline your child, which parent usually does this and how?

_____

_____

Please give any other information which you believe will be helpful to us in understanding your child. _____

_____

Developmental History

List any information about your child's birth and early childhood which you feel necessary.

_____

Has your child been treated for foot, leg, hip or other problem in the muscle or bone development?_____

Age____ Doctor _____Length and type of treatment?_____

Medical/Surgical History

Child has had:

Hospitalizations Age and reason_____ Serious accidents/injuries Age and treatment_____

_____

Childhood Diseases Dates: Chicken Pox_____ Mumps_____
Scarlet Fever_____ Other_____

Frequent Ear Infections Treatment_____

Surgery/tubes _____Date_____

Eye Condition Treatment_____

Glasses _____Date_____

Convulsions/Seizures Age _____Type _____

Medication_____

Allergies Medications_____

Foods_____

Bee Stings_____ Other_____

Asthma _____Hay Fever_____

Eczema_____