



Meeting Street Bright Futures

Developmental History

Child's Name: _____ **DOB:** _____

1. Is this your child's first classroom experience? Yes No
If yes, where/when did he attend before?

2. Describe your child's disposition (i.e.: happy, excitable, shy, curious)

3. Has your child's hearing and vision been tested? Yes No
If yes, please elaborate (where/when/results):

4. Is/Was your child involved with Early Intervention? Yes No
If yes, please elaborate:

5. Other than his or her pediatrician, does your child see any other doctors?
Yes No If yes, please elaborate:

6. Is your child receiving any therapeutic services from a school department or private agency? Yes No If yes, please elaborate:

7. Do you have any concerns about your child's development (i.e.: speech, fine motor, gross motor, social interactions, behavior)? Yes No If yes, please elaborate:

8. Is there anything else you would like to share that will help us understand your child better?
