

Great New Beginnings, Inc.

Pre-Enrollment Questionnaire for Parents

(To better help us care for your child's individual needs please fill out the following information. **Thank You.**)

FAMILY AND SOCIAL HISTORY

Name of Child: _____ Date of Birth: _____

Mother (or Guardian): _____ Age: _____

Father (or Guardian): _____ Age: _____

MARTIAL STATUS OF PARENTS

Living Together: _____ Stepmother: _____
(Name/How Long)

Separated: _____ Stepfather: _____
(How Long) (Name/How Long)

Divorced: _____ Remarks: _____
(How Long)

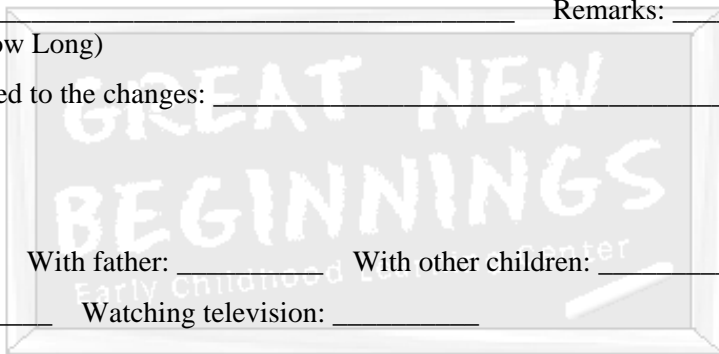
How has your child adjusted to the changes: _____

TIME

Average hours spent daily:

With mother: _____ With father: _____ With other children: _____

With other adults: _____ Watching television: _____



Indicate the kinds of things you believe your child would enjoy doing:

_____ books, puzzles, blocks

_____ scissors, paste, glue

_____ Lego's, tinker toys, take-apart toys

_____ balls, jump ropes, trikes

_____ table games (manipulatives)

_____ rattles, teethingers, hand-held toys

_____ push or pull toys

_____ paper, pencils, crayons

_____ trucks, trains, cars

_____ dolls, dress-ups, dishes

_____ mud, water, sand, play-doh

_____ climbers, steps, slides

_____ busy boxes, sorters

_____ other (please give examples)

OTHER FAMILY / OTHER CARE

Brothers and sisters of the child:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Other members of the household: (include relationship and age): _____

If both parents are away from home during the day, please state arrangements for child's care when he/she is not at school: _____

Does child have his/her own room: _____ If not, with whom? _____

Who has cared for child other than his/her parents? (State whether adults or teenagers)

Has child had group play experience? _____ Where? _____

Does child have neighborhood playmates? Specify: _____

Will your child play contentedly by his/herself? _____

SLEEPING

Has your child shown any sleeping problems? Yes _____ No _____

If yes, what kind? _____

How long does your child typically sleep at night? _____

What is the child's sleeping pattern for the day? A.M. _____ P.M. _____

Does the child prefer to sleep on his/her stomach, side, or back? _____

Do you have any special ways of helping your child go to sleep? _____

If yes, what are they? _____

Does your child usually cry when going to sleep? _____

If yes, how long? _____

Does your child cry when waking up? _____

Does your child sleep in his/her own room? _____

SOCIAL

How does your child play with other children? _____

What are the names of some friends? _____

Does your child prefer playing alone? _____

Does your child seek a lot of adult attention while playing? _____

Has your child attended any other babysitter, day care or nursery program? If so, where and for how long (age)?

Were there things he/she disliked about that experience? _____

Have you and your child had any extended separations from each other? How long and for what reason? Who cared for him/her during that time? _____

How does your child act now when you have to leave him/her? What do you find is best to say or do at these times? _____

How does your child respond to strangers at this time? _____

How does your child most easily adjust to new situations and experiences? _____

At this time, how long does your child stay with a particular activity such as books or blocks?

Infants and Toddlers: When I am unhappy, I like: _____

INTERESTS

How many hours of television does your child watch per day? _____ Favorite programs _____

What are your child's favorite toys? _____

What are your child's favorite activities? _____

HEALTH

How healthy is your child? _____

Has your child had any serious illness or injuries? _____

If yes, explain _____

Does your child have medicine everyday? _____

If yes, what and why? _____

Does your child have any medical allergies? _____

If yes, to what? _____

Does your child have any special fears? _____

If yes, to what? _____

FEEDINGS

(Applicable only for children who are still using a bottle)

Has your child had any feeding problems? Yes _____ No _____

If yes, what are they? _____

Does your child have a good appetite and show interest in food? Yes _____ No _____

What are your child's favorite foods? _____

What foods does your child dislike? _____

What do you do if your child refuses particular food? _____

Have you noticed any allergies or sensitivities to particular foods? _____

If yes, what are they? _____

Is the baby: Breast-fed? _____ Bottle-fed? _____

Do you give the baby a vitamin/mineral preparation regularly? Yes _____ No _____

What foods is your baby eating now?

Fruits _____	Juices _____
Vegetables _____	Meats _____
Cereals _____	Milk _____
	Formula _____

DISEASES AND CONDITIONS

Has your child had any of the following?

	Yes	No
Whooping Cough	_____	_____
Mumps	_____	_____
Measles (Red)	_____	_____
Measles (German)	_____	_____
Chicken Pox	_____	_____
Pneumonia	_____	_____
High temp. (over 103)	_____	_____
Allergy, Eczema	_____	_____
Injuries	_____	_____
Neurological	_____	_____
Others	_____	_____

TOILETING/SELF CARE SKILLS

Is your child toilet trained? _____

How many accidents does he/she have per day, per night/nap? _____

Can your child dress him/herself? _____

Are there any special words or routines about toileting that we should know? _____

Infants and Toddlers: If my bottom gets sore, I like: _____

My bowel movements are usually: _____ (consistency) and I usually have my bowel movements at _____ (time).

OTHER:

Describe any of your child's fears: _____

Describe any unfortunate events that happened to your child: _____

Describe any pets: _____

List pet names: _____

Does your child take responsibility in dressing? _____ in washing? _____

List your "three most important rules" for your child:

1. _____

2. _____

3. _____

Describe most common method of discipline: _____

What do you hope your child will gain most from his/her experiences here? _____

Describe any physical birthmarks, scars, etc. your child may have: _____

Is there any other information about your baby special likes and dislikes or way you give care that would be helpful for caregivers to know in order to take better care of your baby?

What would you like your child to get from this experience?