Getting to Know Me

Child's full name _____ Name child goes by _____
Language spoken at home _____ Completed by _____

Activity/Routine	
Sleep Naps/bedtime Falling asleep Sleeping through the night Waking up	What does your child do? How do you help? What, if anything, would make it easier?
Mealtime/Feeding Where child eats Time it takes to eat Variety of foods/favorites Feeding self (bottle/cup, utensils)	What does your child do? How do you help? What, if anything, would make it easier?
Dressing/Diapering Putting on/taking off (shirt, (pants, coat, shoes, etc.)	What does your child do? How do you help? What, if anything, would make it easier?
Toileting/Hygiene Washing hands, wiping face and nose Brushing teeth Potty training skills	What does your child do? How do you help? What, if anything, would make it easier?

Playing Explore surroundings Favorite toys/activities How child plays with toys Interest in books/songs Outdoor play	What does your child enjoy playing with? Do you have any concerns?
Interacting Separating from parents Attention span/activity level Feelings (including any fears)	How does your child play and interact with others: Do you have any concerns?

Is your child receiving any special services (e.g. Early Head Start, private therapy, etc.)**? Does you child have a current IFSP or IEP?** _____

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Do you have any other concerns you would like to share with us (behavior, family issues, etc.)**?** _____

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