

# All About Me



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Country of Birth: \_\_\_\_\_ Language spoken at Home: \_\_\_\_\_

Child's Position in Family: \_\_\_\_\_

Siblings Names:



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

Age: \_\_\_\_\_

Age: \_\_\_\_\_

Age: \_\_\_\_\_

Has there been any changes that may have affected your child (i.e. new baby, moving, illness in family, parent information?)

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## Sleeping Habits



When and how long does your child sleep during the day?

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Does your child have a security item? (i.e. dummy, blanket)

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## Nappies & Toileting

Is your child toilet trained?

☐ Yes ☐ No

Does your child need assistance when using the toilet?

☐ Yes ☐ No

Does your child wear a nappy to sleep?

☐ Yes ☐ No



## Social Experiences

What experience has your child had of being separated from you?

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What was your child's reaction to separation?

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### Do you have any pets?

Type: \_\_\_\_\_

Name: \_\_\_\_\_

Type: \_\_\_\_\_

Name: \_\_\_\_\_

Type: \_\_\_\_\_

Name: \_\_\_\_\_

### Interests

What are your child's favourite activities?

Indoors:

\_\_\_\_\_

Outdoors:

\_\_\_\_\_

Are you happy for your child to join in with messy play?

☐ Yes ☐ No



### Other Information

Does your child suffer from any allergies or intolerances? ☐ Yes ☐ No

If 'Yes' please provide details of allergies/intolerances:

\_\_\_\_\_

Do you have any concerns about your child's:

Speech Development ☐ Yes ☐ No

Hearing ☐ Yes ☐ No

Behaviour ☐ Yes ☐ No

Sight ☐ Yes ☐ No

Other: \_\_\_\_\_

If 'Yes' have you accessed support from any of the following services:

Speech Pathologist ☐ Yes ☐ No

Audiologist ☐ Yes ☐ No

Occupational Therapist ☐ Yes ☐ No

Psychologist ☐ Yes ☐ No

Dietician/Paediatrician ☐ Yes ☐ No

Other: ..... ☐ Yes ☐ No

ECIS (Early Childhood Intervention Services) ☐ Yes ☐ No

If 'Yes' but have not accessed support from any of the above services, can we help you? ☐ Yes ☐ No

