

# One Year of Age & Older Personal Care Information



Please fill out the following information regarding your child's medical and social history so that we may better serve you and your child.

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Siblings (gender & age):  
\_\_\_\_\_

Who does your child live with? \_\_\_\_\_

Any serious illness or hospitalization? \_\_\_\_\_

Any physical disabilities? \_\_\_\_\_

Does your child receive any special services (OT, speech, etc.)?  Yes  No If yes, explain:  
\_\_\_\_\_

Difficulties in speaking?  Yes  No Other languages? \_\_\_\_\_

Special words to describe needs: \_\_\_\_\_

Any known allergies?  No  Yes – please list w/symptoms: \_\_\_\_\_  
\_\_\_\_\_

Any medications given regularly? \_\_\_\_\_

Are there any foods/products your child cannot eat/use? \_\_\_\_\_  
\_\_\_\_\_

Has your child learned to use the toilet appropriately and successfully?  YES  NO

If NO, please describe the toilet learning methods you use at home with your child:  
\_\_\_\_\_  
\_\_\_\_\_

If YES, can your child be relied upon to indicate their bathroom wishes?  Yes  No

How often does your child have toilet accidents? \_\_\_\_\_

What time does your child go to bed? \_\_\_\_\_ Awaken? \_\_\_\_\_

Does your child nap?  Yes  No How long? \_\_\_\_\_ When? \_\_\_\_\_

Has your child ever been enrolled in school? \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child transition well (saying goodbye, moving from one activity to the next, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No

What does your child enjoy?

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Is there anything else you would like us to know about your child that would help us understand them better?

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