

Robin's Nest



Background Record

Child's Name _____ Nickname _____

Other Members of family (parents, siblings, others) living at home

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had previous group experiences? If so, please describe.

Is your child accustomed to being away from home or family? _____

Do you use baby-sitters? _____ If so, how often? _____

What does your child like to do most? _____

Does your child have any specific fears? If so, please describe _____

How many hours does your child sleep at night? _____

Does your child nap? If so, what is his/her schedule? _____

Does your child have sleeping difficulties? If so, please explain _____

What toilet words do you use? _____

Is your child trained? _____ If so, what age _____

Daytime control established? _____ Nighttime _____