# Child Portrait

Please complete and return to the center by your child’s first day of attendance. This will assist staff in getting acquainted with your child and in helping your child adjust.

Date: _______________  Person completing form: _____________________________________

Child’s Name: ___________________________________________________________________________

<table>
<thead>
<tr>
<th>Children in Family/Household</th>
<th>Children’s ages</th>
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<td>1. ________________________</td>
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<td>5. ________________________</td>
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<tr>
<th>Others in Family/Household</th>
<th>Relationship</th>
<th>Occupation</th>
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<tbody>
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1. Does your child prefer playing alone? _____ with other children? _____ List names of favorite playmates:

_______________________________________________________________________________________

2. What is your child’s most favorite toy? _________________________________________________

Most favorite activity? ________________________________________________________________

3. List your child’s pets ________________________________________________________________

Names of pets? ________________________________________________________________

4. Has your child attended any children’s groups such as Day Care? _____ Sunday School? _____
Vacation Bible School? _____ Nursery School? _____ Other? ___________________________________

5. What method of control, discipline, teaching do you find most effective? ____________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________
6. Is there anything in particular which frightens your child?

_______________________________________________________________________________________
_______________________________________________________________________________________

7. Has your child had severely upsetting experiences such as divorce of parents, death in family, frequent or recent moves, etc?

What were his/her reactions?

_______________________________________________________________________________________

8. As a rule, is your child’s appetite excellent? _____  good? _____  fair? _____  poor? _____

9. List foods not allowed to eat ____________________________

10. Favorite foods ____________________________

11. Disliked foods ____________________________

12. Is toilet control established at daytime? ___________  during night? _______________

13. How does your child indicate need for urination? ____________________________
    bowel movement? ____________________________

14. Describe any difficulties observed with your child’s:
    Hearing ____________________________
    Vision ____________________________
    Other ____________________________

15. Other information you feel might be helpful in working with your child in the center (including but not limiting cultural customs, home languages, religious observances, ethnicity, etc.): ____________________________
    __________________________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________
    __________________________________________________________________________