**COLONIAL EARLY EDUCATION PROGRAM (CEEP)**

The Colwyck Center  
12 Landers Lane  
New Castle DE 19720  
Office 302-429-4055  
Fax 302-429-4057

**BACKGROUND HISTORY**

Child's Name: ____________________________

<table>
<thead>
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<th>First</th>
<th>Middle</th>
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Birthdate: ______/_____/____  
Age: ______  
Gender: M____ F____  
Race: ____________

Mother's Name: ____________________________  
Age: ______

Father's Name: ____________________________  
Age: ______

Legal Guardian's Name (if applicable): ____________________________  
Age: ______

Person Completing this Form: ____________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to child</th>
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With whom does the child live? _____________________________________________________________________________

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<th>Name</th>
<th>Relationship to child</th>
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Parent's or Legal Guardian's Street Address:

<table>
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<tr>
<th>Street</th>
<th>Apt.# (if applicable)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Parent's or Legal Guardian's Mailing Address (if different from above):

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<th>Street</th>
<th>Apt.# (if applicable)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Home Phone: ____________________________  
Cell Phone: ____________________________

Work Phone (mother): ____________________________  
Work Phone (father): ____________________________

Email: ____________________________

In which school district is your child's home located? ____________________________________________

Does your child attend a childcare/daycare facility? ________ If yes, which childcare/daycare facility?

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<th>Name of facility</th>
<th>Address of facility</th>
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Language(s) spoken in the home: ________________________________

Other adults living in the home:

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<th>Name</th>
<th>Relationship</th>
<th>Name</th>
<th>Relationship</th>
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Other children living in the home:

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<tr>
<th>Name</th>
<th>Age:</th>
<th>Relationship</th>
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**BIRTH HISTORY**

Were there any problems during pregnancy? Yes ______ No_______

If yes, please explain: __________________________________________
  __________________________________________
  __________________________________________
  __________________________________________

Length of pregnancy: Full Term_______ Premature_______ How many weeks?

Type of delivery: Normal_______ Breech_______ Forceps_______ Caesarean_______

Birth Weight: ________________ Baby’s condition at birth: ______________________

Any complications during delivery? Yes ______ No_______

If yes, please explain: __________________________________________
  __________________________________________
  __________________________________________

Length of hospital stay: ________________

Any complications during hospital stay? Yes ______ No_______

If yes, please explain: __________________________________________
  __________________________________________
  __________________________________________
# HEALTH HISTORY

Name of your child’s physician: ____________________________________________

First  Last

Physician’s telephone number: ( ) ____________________________________________

Has your child’s hearing been tested? Yes ________ No ________
If yes, when? ______________________

Results of testing: ____________________________________________________

Does your child have a history of ear infections? Yes ________ No ________
If yes, when was the first ear infection? ________ When was the most recent infection? ________

How often has your child had ear infections?

- Frequently________
- Occasionally________
- Seldom________
- Never________

Has your child ever had tubes surgically placed? ________________________________

Has your child’s vision been tested? Yes ________ No ________
If yes, when? ______________________

What were the results of the testing? ________________________________________

Are there any other physicians or specialists who have treated your child? If yes, please list:

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<th>Name</th>
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<th>Telephone Number</th>
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Does your child have any significant health problems? Yes ________ No ________

If yes, explain __________________________________________________________

____________________________

____________________________

Is your child currently taking any medications? Yes ________ No ________

If yes, please list: ______________________________________________________

____________________________

____________________________

____________________________
CHILD’S DEVELOPMENT

Do you have concerns about your child’s development?  Yes ______ No ______
If yes, explain: _____________________________________________________________
___________________________________________________________________________

Is your child toilet trained? Yes ______ No ______ If yes, at what age did he/she train? ______

Does your child regularly drink from an open cup? Yes ______ No ______
If no, what does he/she use? ________________________________________________

Did/does your child have frequent use of a pacifier? Yes ______ No ______

Does your child have a history of choking or difficulty swallowing? Yes ______ No ______
If yes, explain: _____________________________________________________________
___________________________________________________________________________

Has your child ever received special education services (including early childhood, speech therapy, occupational therapy, physical therapy)? Yes ______ No ______
If yes, please list:

<table>
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<tr>
<th>Type of service</th>
<th>When</th>
<th>Where</th>
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SPEECH AND LANGUAGE DEVELOPMENT

When did your child first use his/her first words meaningfully? ______________________________

How does your child most frequently communicate with you? Check all that apply:
Sounds______ Single Words______ Phrases or Sentences______ Gestures______ Pointing______
Leads to desired objects______ Other (please describe) _____________________________________

How well is your child understood by others?

Parents  Poor____  Fair____  Well____
Siblings  Poor____  Fair____  Well____
Playmates  Poor____  Fair____  Well____
Does your child use at least 50 words? Yes _____ No______ If no, how many words? ____________

Is your child able to have a simple conversation with you? Yes _____ No______

Does your child have difficulty understanding other's questions or following directions? Yes ___ No____

If yes, when have you observed this? ________________________________

If your child has difficulty understanding or communicating, how does he/she react to this difficulty?

________________________________________________________________________

What has been the general course of communication difficulty?

Getting better _______ Remained the same _______ Getting worse _______


CHILD'S BEHAVIOR

What are your child's favorite activities or toys? ________________________________

Is your child able to play by himself/herself for a short time? Yes ___ No____

Does your child like to play with other children? Yes ___ No____

Please describe any frequent behavior problems that you may have with your child: ________________________________

________________________________________________________________________

________________________________________________________________________

What are your child's strengths? ________________________________

________________________________________________________________________

________________________________________________________________________

FAMILY HISTORY

Is there a family history of speech, language or learning problems? Yes ____ No____

If yes, please describe the type of problem and who had the problem: ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
DAYCARE AND PRESCHOOL HISTORY

If your child attends a **daycare**, please answer the following:

Type: Public_____  Private_____  Home_____  Family Member’s Home_____

Name of Daycare: ______________________________________________________
Address: ______________________________________________________________
Telephone Number: ______________________________________________________
Contact Person: __________________________________________________________

How many days and hours does your child attend daycare?  _____ days per week, _____ hours per day.
Has the daycare provider expressed any concerns about your child?  Yes ___  No___
   If yes, please explain: ______________________________________________________

If your child attends **preschool**, please answer the following:

Type: Public_____  Private_____  Home_____

Name of Preschool: ______________________________________________________
Address: ______________________________________________________________
Telephone Number: ______________________________________________________
Contact Person: __________________________________________________________

How many days and hours does your child attend preschool?  _____ days per week, _____ hours per day.
Have the preschool teachers expressed any concerns about your child?  Yes ___  No___
   If yes, please explain: ______________________________________________________

Has your child recently changed daycare or preschool settings?  Yes ___  No___
   If yes, please explain: ______________________________________________________

Is there anything else you would like the assessment team to know about your child or family? ____________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
It is important to Colonial School District staff members to be respectful to and understanding of all of our families. Please answer the following cultural questions so that we may understand and support your child and your family.

List any special holidays, customs, or celebrations that are important to your child or your family:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

List any food items that your child or your family does not eat due to cultural or religious reasons:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

List any religious or cultural beliefs that your family has or any information that you would like to share to help our staff better understand your culture and beliefs:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

List all languages your child is learning or exposed to in the home:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________