CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name: _____ ☐ M ☐ F Birthday:_____ Age:_____
Languages spoken at home: _____
Parent/Guardian Name (s): _____
Person Completing form: _____ Date: _____
How often does your child see a doctor or nurse? _____ Date of last dental checkup? _____
Date of your child's most recent comprehensive vision (eye) Exam, if your child received one: _____
The comprehensive vision exam is performed by an optometrist or ophthalmologist.

Does your child have health insurance? ☐ Yes ☐ No ☐ Applied

Please check the boxes if your or your child use, if any:

☐ Early Childhood Family Education	☐ Child & Teen Check-Ups	☐ Child Care Center
☐ Early Childhood Special Education	☐ School-Based-Pre-K	☐ Family/Neighbor Care
☐ Follow Along Program	☐ Private Preschool	☐ Library
☐ Parenting Education	☐ Head Start	☐ WIC
☐ Parks and Recreation Programs	☐ Foster Care	☐ Food Shelf

HEALTH
Please check any concerns that apply to your child and describe:

☐ Allergies: ☐ Food ☐ Medicine ☐ Animals/Insect ☐ Dust/Mold ☐ Seasonal _____
☐ Takes medicines, herbs and/or vitamins: _____
☐ Visits to health specialist(s), hospital stays and/or surgeries: _____
☐ Serious injuries or illnesses, visits to Emergency Room. Reason & Date: _____
☐ Head Injuries (loss of consciousness?) _____
☐ Lead poisoning, level if known: _____
☐ Trouble breathing, coughing or asthma: _____
☐ Skin problems or rashes: _____
☐ Seizures, staring spells: _____
☐ Vision problems or wears glasses: _____
☐ Ear (PE) tubes or hearing problems: _____
☐ Teeth: One or more cavities: _____
☐ Eating, stomach concerns or constipation: _____
☐ Mental health concerns such as anxiety, depression or attention concerns? _____
☐ Adopted, If Yes, at what age: _____
☐ Problems during pregnancy or birth? _____
☐ Born more than three weeks early or late _____ # weeks at birth. Child's Birth Weight: _____
☐ At birth, stayed in the hospital longer than mother, reason: _____
☐ Is it possible that before you knew you were pregnant you: ☐ drank alcohol ☐ smoked cigarettes
☐ used street drugs ☐ took prescription medication (list) _____
Please List any other concerns: _____

Please check any Family Health problems (child's parents or siblings):

☐ Attention problems	☐ Vision Problems	☐ Diabetes
☐ Allergy	☐ Learning Problems	☐ Growth Problems
☐ Asthma	☐ Mental Health Disorders	☐ Epilepsy/Seizures
☐ Deafness/Hearing	☐ Sickle Cell Anemia/Trait	☐ Other Health Problems

CHILD'S DAILY ROUTINES

_____Sleeps at _____PM. Wakes up at _____AM.

☐ Has difficulty falling/staying asleep

☐ Takes a nap: from_____ to _____

☐ Gets 60 minutes or more of exercise each day

☐ Is NOT able to/does NOT get 60 minutes of exercise

____ TV/Video Game/Screen Time: hours per day

Every day eats some food from the good groups:

☐ 5-9 servings fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

☐ 3 servings calcium rich foods: milk, cheese, yogurt, soymilk, tofu

☐ 2-3 serving iron rich foods: fish, poultry, meat, beans, legumes, eggs

☐ 3 or more servings: Whole Grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta

☐ More than one serving of sweets, fruit drinks or junk food each day

In the past 12 months, we worried whether our food would run out before we could by more ☐ Yes ☐ No

In the past 12 months, the food we bought didn't last and we didn't have money to get more ☐ Yes ☐ No

HOME SAFETY

Current Housing Situation:

☐ Renting or Homeowner ☐ Doubled up with friends or family ☐ Hotel or Motel

☐ Emergency Shelter/Transitional Housing ☐ Unsheltered (cars, parks, and campgrounds, temporary)

Does your child live or play in a home or building built before: ☐ 1978 ☐ Remodeled in the last 5 years?

Does anyone at home or who cares for your child: ☐ Use tobacco/smoke ☐ Use alcohol ☐ Have a gun (use safety lock)

Do you have concerns that your child is exposed to: ☐ Violence ☐ Street Drugs ☐ Unsafe Conditions

Do you and/or your child use/have the following:

☐ Car Seats ☐ Bike Helmets ☐ Smoke Detector ☐ Carbon Monoxide Detector

Learning

☐ My child learned to do things at the same age as other children (sit, stand, walk, toilet trained, ect.)

If not, please explain: _____

My child needs help with: □ Toileting □ Activity/Mobility □ Dressing □ Nutrition/Eating (Help to Eat Oranges? Milk?)

Other: _____

Please check any of the following:

☐ Says numbers 1 to 10	☐ Understands other people
☐ Has trouble speaking or hard to understand	☐ Able to follow directions
☐ Has trouble being understood by others	☐ Plays in a variety of ways
☐ Seems clumsy when using hands	☐ Walks or runs poorly (falls)