Child Health and Developmental History (3-6 Years)

Name:	Gender:	Birthdate:
MARSS ID (for office use only):		
Languages Spoken at home:		Age:
Parent/Guardian Names:		
Person completing the form:		Date:

How often does your child see a doctor or nurse?	Date of last well child visit:
How often does your child see a dentist?	Date of last dental check-up:

Date of your child's most recent comprehensive vision (eye) exam, if your child recieved one: _____ the comprehensive vision exam is performed by an optometrist or ophthalmologist

Does your child have health insurance? __Yes __No ___Applied

Do you or your child participate in any of the following? (check all that apply):

__Early Childhood Family Education	__Child & Teen Check ups	__Child Care Center
__Early Childhood Special Education	__School-Based PreK	__Family/Neighbor Care
__Follow along Prgram	__Private PreK	__Library
__Parent Education	__Head Start	__WIC
__Parks and Recreation Programs	__Foster Care	__Food Shelf

HEALTH

Pleae check any concerns that apply to your child and describe:

__ Allergies: __Food __Medicine __Animals/Insect __Dust/Mold __Seasonal

__Takes medicines, herbs and/or vitamins

__Vistis to health specialist(s), hospital stays and/or surgeries:

__Mental health concerns such as anxiety, depression or attention concerns?

__Head injuries (loss of consciousness?)	__Skin problems or rashes
__Lead poisoning, Level if known	__ Trouble breathing, coughing or asthma
__Seizures, staring spells:	__Vision problem or wears glasses
__Ear (PE) tubes or hearing problems	__Teeth: one or more cavaties
__Eating, stomach concrns or constipation:	__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 long than mother, reason:

__Is it possible that before you knew you were pregnant you took medications, alcohol, cigarettes, or street drugs?

__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	__Epileps/Seizures
__Deafness/Hearing	__Sickle Cell Anemia/Trait	__Other health problems

Child's Daily Routines	
Sleeps at _____PM Wakes at _____AM	Gets 60 minutes or more of exercise each day Yes or No
Has difficulty falling or staying asleep __Yes __No	
Takes a nap: from _____ to _____	___TV/Video Game/Screen time (hours per day)
How many servings per day does your child eat foods from the food groups:	
__Fruits/Vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas, etc.	
__Calcium rich foods: milk, cheese, yogurt, soymilk, tofu, etc	
__Iron rich foods: fish, poultry, meat, beans, legumes, eggs	
__Whole grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta	
__Sweets, fruit drinks or junk food	
In the past 12 months, we worried whether our food would run out before we could buy more __Yes __No	
In the past 12 months, the food we bought didn't last and we didnt' have money to get more __Yes __No	

HOME SAFETY

Current housing situation:
__Renting or home owner __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 gun (saftey 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, etc)

If not, please explain:

My Child needs help with:
__Toileting __activity/mobility __Dressing __Eating __Other _____

Please check all that apply:

__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)