CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name:_____ __M __F Birthdate: _____ Age _____
(For office use only)
MARSS other ID: _____ 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 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 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 you 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, visit to Emergency Room. Reason and date: _____

_____Head injuries (loss of consciousness?)_____

_____Lead poisoning, level if known: _____

_____Trouble breathing, coughing or asthma:_____

_____Skin problems or rashes:_____

_____Seizures, staring spells:_____

_____Vision problem 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 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	_____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 foods from the food 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 buy 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 _____with friends or family _____hotel or motel

_____emergency shelter/transitional housing

Does your child live or play in a home or building built before: ___1978 ___remodeled in last 5 years?

Does anyone at home or who cares for your child: ___use tobacco/smoke ___ use alcohol ___have a gun

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 _____nutrition/eating

Other:_____

Please check any of the following:

_____Says numbers 1 to 10

_____Has trouble speaking or hard to understand

_____Has trouble being understood by others

_____Seems clumsy when using hands

_____ understands other people

_____ Able to follow directions

_____ Plays in a variety of ways

_____ Walks or runs poorly (falls)