

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 (ECFE)	_____ Child & Teen Checkups	_____ Child Care Center
_____ Early Childhood Special Education (ECSE)	_____ School Readiness	_____ Family/neighbor care
_____ Follow Along Program	_____ Private Preschool	_____ Library
_____ Parenting Education	_____ Head Start	_____ WIC
_____ Park and Rec programs	_____ Foster Care	_____ Food Shelf

HEALTH

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

_____ Allergies __ foods __ medicines __ animals/ insects __ 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 3 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
___ Allergy
___ Asthma
___ Deafness/Hearing

___ Vision problems
___ Learning Problems
___ Mental Health Disorders
___ Sickle Cell Anemia/Trait

___ Diabetes
___ Growth Problems
___ Epilepsy/Seizures
___ 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: ___ housed (rental or homeowner) ___ staying with friends or family
___ staying in emergency shelter/transitional housing ___ staying in hotel or motel

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 and safety equipment ___ smoke detector ___ carbon monoxide detector

LEARNING

___ My child learned to do things at the same age as other children (sit, stand, walk, become 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

___ 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)