POTTSGROVE HEALTH SERVICES
KINDERGARTEN HEALTH HISTORY

PERSONAL INFORMATION

Child's Name:_____ Sex***: M / F*** Birth Date:_____
Last First Middle
Mother's Name:_____
Last First Middle Maiden Name
Father's Name:_____
Last First Middle
Person(s) child resides with:_____
Person(s) having legal custody:_____
Person completing form:_____

BIRTH HISTORY

Birthplace:_____ Birth Weight:_____ Length:_____
Mother's age at time of birth:_____
Was your child born: ____Full term or ____Premature (Explain)_____
Please list any complications of pregnancy, labor, or delivery_____
_____
Were any substances such as medication, alcohol, drugs, cigarettes, etc. used during the pregnancy? Please explain: _____

DEVELOPMENTAL HISTORY

Please check any developmental milestones that were delayed:
____Sitting unsupported
____Crawling
____Walking
____Feeding self
____Talking
____Toilet training

Please check all activities that your child is able to do independently:
____Button
____Zip
____Snap
____Tie shoes
____Cut with scissors

Which hand does your child use most often?
____Right
____Left
____Both hands

Please check instances where your child has had the opportunity to interact with other children:
____Pre-School
____Sunday School
____Siblings
____Neighbors
____Play groups

BEHAVIORAL HISTORY

My child experiences the following: (Please check all that apply)

____Irritability
____Short attention span
____Temper tantrums
____Defiant of authority
____Fears
____Nail biting
____Bedwetting
____Tics
____Negative reaction to affection
____Trouble separating from parent
____Difficulty expressing needs
____Stuttering
____Unclear Speech
____Exhaustion if no nap
____Nightmares
____Soiling/wetting during the day
____Difficulty holding a pencil
____Difficulty holding scissors
____Overactive behavior
____Difficulty getting along with friends

MEDICAL HISTORY

Please check and explain all that apply:

____Allergies_____
____Medications_____
____Hospitalizations (Date)_____
____Serious Illnesses (Date)_____
____Serious Injuries (Date)_____
____Skin afflictions_____
____Heart problems_____
____Lung or breathing problems_____
____Neurological problems _____
____Digestive or stomach problems_____
____Bowel problems_____
____Bladder problems_____
____Muscle, bone, or joint problems_____
____Vision problems_____
____Hearing problems_____

Please check and explain any services that your child receives:

____Physician or Doctor_____
____Mental Health Provider_____
____Speech Therapist_____
____Occupational Therapist_____
____Physical Therapist_____
____Early Intervention Program_____

FAMILY MEDICAL HISTORY

Please list any family medical history (diabetes, heart disease, cancer, strokes, allergies, disabilities, mental illnesses):_____

ADDITONAL INFORMATION

Please list any additional concerns that you may have_____
_____
_____