Child's Name:

Birthdate: _____ Age: _____

Parent/Guardian Name: _____

Person Completing Form: _____

Date: _____

CHILD HEALTH AND DEVELOPMENTAL HISTORY (3 - 6 YEARS)

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
☐ Early Childhood Special Education
☐ Follow Along Program
☐ Parenting Education
☐ Parks and Recreation Programs
☐ Child & Teen Check-ups
☐ School-based Pre-K
☐ Private Preschool
☐ Head Start
☐ Foster Care
☐ Child Care Center
☐ Family/Neighbor Care
☐ Library
☐ WIC
☐ 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 breating, 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, that 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 ☐ Gets 60 minutes or more of exercise each day ☐ Does NOT get 60 minutes of exercise

☐ Takes a nap from _____ to _____

☐ _____ Hours per day of TV, Video Game, or Screen Time

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 servings 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 ☐ 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 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 detectors ☐ carbon monoxide detectors

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 (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)