CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-5 YEARS)

Date Screening Completed: _____ Person Completing: _____

Child's Name: _____ _____M _____F Birthdate: _____

Age: _____ **(For office use only)**
Child/Student MARSS ID or Record #: _____

Parent/Guardian Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Who lives with your child? _____

Language (s) spoken in the home: _____

How often does your child see a doctor or a nurse? (number of visits per year) _____

How often does your child see a dentist? (number of visits per year) _____

Do you have health insurance? _____Yes _____No

Insurance provider: _____ Group #: _____

Do you have questions or concerns about your child? We can talk about them today.

Please list concerns: _____

Please describe your child's special needs and strengths: _____

Please check the boxes if you or your child use:

_____ Early Childhood Family Education (ECFE) _____ Child and Teen Checkups
_____ Follow Along Program _____ Head Start _____ School Readiness
_____ Parenting Education _____ WIC _____ Food Pantries

Please check the areas if you have concerns or questions about your child's:

_____Health _____ Learning _____ Behavior _____Talking _____ Growth
_____Skin/bruising, rashes _____ Eyes/vision _____ Ears/hearing _____ Nose
_____Throat _____ Teeth _____ Mouth _____ Stomach _____ Toileting
_____Activity level _____ Walking/balance _____ Social/friends _____ Feelings/moods
_____Breathing/coughing _____ Headaches
_____General appearance _____Other

HEALTH

Please check all that apply to your child and describe:

_____ Allergies to foods and/or medicines_____

_____ Takes medicines, herbs and/or vitamins _____

_____ Visits to health specialists _____

_____ Serious illnesses _____

_____ Serious injuries or loss of consciousness _____

_____ Hospital stays and/or surgeries _____

_____ Problems during mother's pregnancy or birth _____

_____ At birth stayed in the hospital longer than mother _____

_____ Members of the same family sometimes have the same health problems. Please list family health problems: _____

EATING HABITS

Please check all that describe your child:

_____ Drinks from a cup _____ Drinks from a bottle _____On a special diet

Every day eats some foods from the food groups:

_____ Fruits (oranges, apples, bananas, mangos, tomatoes)

_____ Vegetables (spinach, corn, peas, potatoes, cabbage

_____ Milk, cheese, yogurt, tofu

_____ Meat, fish, poultry, peanut butter, beans, legumes, eggs

_____ Cookies, cakes, candy, pie, butter, fried foods

_____ Bread, cereal, rice, tortillas, crackers, pasta

Every day drinks:

____ Milk ____ Juice ____ Fruit drinks ____ Formula

____ Kool-aid ____ Water ____ Pop

HOME

Please check all that describe your child:

Does your child live or play in a home or building built before: ___1950 ___1978 and is being remodeled

Does anyone in your home or who cares for your child:

_____ Use tobacco _____ Use alcohol _____ Have a gun

Is your child exposed to: _____Violence _____ Street drugs _____ Unsafe conditions

Do you have questions, concerns, or want information about:

_____ Bike helmet/safety _____ Emergency hotline _____ Lead poisoning

_____ Stranger safety _____ Carbon monoxide _____ Phone numbers

_____ Parenting issues _____ Severe weather plans_____Seat belts/car seats

_____ TV watching _____ Child care _____ Family relations _____ Sleeping

_____ Poisoning (syrup of Ipecac) _____ Teaching your child _____ Child rearing

_____ Fire escape plan _____ Smoke detectors _____ Toilet training _____Crying

_____ Gun Safety _____Protective sports gear _____ Discipline

_____ Kindergarten _____ Storing cleaning supplies/medication

_____Toy/playground safety

LEARNING

Please check all boxes that describe your child:

_____Says numbers from 1 to 10
_____Stutters, stammers
_____Have trouble being understood
_____Understands other people
_____Points to or names the bigger of two objects
_____Understands "one" or gives you just one when asked
_____Seems timid, fearful, or worries a lot
_____Compares things, for example, says "this one is bigger, heavier"
_____Acts much younger than age
_____Counts three or more objects
_____Copies circles or other shapes
_____Tells when one object is lover or shorter
_____Prints first name or part of it

_____Seems clumsy when using hands
_____Seems clumsy, stumbles, falls, walks or runs poorly
_____Seldom plays with other children
_____Clings or gets very upset when leaving you
_____Seems overly friendly
_____Knows how many fingers are on each hand
_____Seems unhappy, cries, whines
_____Has trouble paying attention
_____Seems overly aggressive
_____Has trouble sitting still
_____Plays in a variety of ways

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