**Child Health and Developmental History (3-5 Years)**

Person Completing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child's Name:­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male/Female: Circle one Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Guardian Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents married?­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If parents are separated or divorced, who has legal custody?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives with your child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language(s) spoken in 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\_\_\_\_\_

If yes, Name of insurance provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have questions or concerns about your child?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please describe your child's special needs and strengths:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assistive Technology Screener –** Assistive Technology is a device or service that is used to increase or maintain functional performance of a child with a disability.

1. What activity, or task, does your child need to increase performance on so he/she can be independent at home and/or school?

 (Examples: carry/organize physical materials to and from school, dress independently, use bathroom independently, complete written work, see/hear/communicate, fine motor skills, gross motor coordination, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health**

**Please describe any of the following that pertain to your child:**

Allergies to foods and or medicines:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to foods and or medicines:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious injuries or loss of consciousness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital stays and/or surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems during mother's pregnany or issues during birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stayed at hospital longer than mother at birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 cup\_\_\_\_\_\_\_\_\_ Drinks from bottle\_\_\_\_\_\_\_\_\_ On a special diet\_\_\_\_\_\_\_\_\_\_\_\_

**Every day he/she eats foods from these food groups:**

|  |
| --- |
| \_\_\_\_Fruits (oranges, apples, bananas, mangos, tomatoes) |
| \_\_\_\_Vegetables (spinach, corn, peas, potatoes, cabbage) |
| \_\_\_\_Dairy (milk, cheese, yogurt, tofu) |
| \_\_\_\_Meat, fish, poultry, peanut butter, beans, legums, eggs |
| \_\_\_\_Cookies, cakes, candy, pie, butter, fried foods |
| \_\_\_\_Bread, cereal, rice, tortillas, crackers, pasta**Every day he/she drinks:**\_\_\_Milk \_\_\_Fruit Drinks \_\_\_Water \_\_\_Kool Aid\_\_\_Pop \_\_\_Formula**Home****Please check if either apply to your child:** |
|

|  |
| --- |
| Does your child live/play in a home or building built before 1950? \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Does your child live/play in a home or building built before 1978 and is being remodeled?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Does anyone in your home or anyone who cares for your child:****\_\_\_\_\_Use tobacco products****\_\_\_\_\_Use alcohol****\_\_\_\_\_Own/have a gun or firearm****Is your child exposed to any of the following:****\_\_\_\_\_Violence****\_\_\_\_\_Street drugs****\_\_\_\_\_Unsafe conditions****Select the programs or services you or your child use, if any:**

|  |
| --- |
| **\_\_\_\_\_Early Childhood Family Education (ECFE)****\_\_\_\_\_Follow Along Program****\_\_\_\_\_Parenting Education****\_\_\_\_\_Head Start****\_\_\_\_\_WIC** |
| **\_\_\_\_\_Child and Teen Checkups****\_\_\_\_\_School Readiness****\_\_\_\_\_Food Pantries****Select the areas in which you have concerns or questions related to your child, if any:****­­­­­\_\_\_\_Health \_\_\_\_Learning \_\_\_\_Behavior \_\_\_\_Speaking ­­­­\_\_\_\_Growth****\_\_\_\_Nose \_\_\_\_Skin/Bruising/Rashes \_\_\_\_Eyes/Vision** **\_\_\_\_Throat \_\_\_\_Mouth \_\_\_\_Teeth \_\_\_\_Ears/Hearing****\_\_\_\_Stomach \_\_\_\_Toileting \_\_\_\_Headaches \_\_\_\_Activity Level****\_\_\_\_Walking/Balance \_\_\_\_Social/Friends** **\_\_\_\_Mood/Feelings \_\_\_\_General Appearance** **Do you have any questions, concerns or want information about:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_Severe Weather Plans |   | Fire Escape Plans |  | Emergency Hotline |
| \_\_\_Seat Belts/Car Seats |   | Bike Helmet/Safety |   | Poisoning |
| \_\_\_Toy/Playground safety |   | Stranger safety |   | Carbon Monoxide |
| \_\_\_Protective Sports Gear |   | TV Watching |   | Child care |
| \_\_\_Teaching Your Child |   | Parenting Issues |   | Smoke Detectors |
| \_\_\_Crying |   | Discipline |  |   | Family Relations |
| \_\_\_Kindergarten |   | Gun Safety |  |   | Child Rearing |
| \_\_\_Phone #'s |  |   | Lead Poisoning |   | Sleeping |
| \_\_\_Toilet Training |  | Child’s Teacher |  |   | Bus/Van Ride |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Learning** |  |  |  |  |  |  |  |  |
| **Please check all that describe your child:** |  |  |  |  |  |
|   | Says numbers from 1 to 10 |  |   | Seems clumsy when using hands |  |
|   | Stutters, stammers |  |  |   | Has trouble sitting still |  |  |
|   | Has trouble being understood |  |   | Seldom plays with other children |  |
|   | Understands other people |  |   | Clings or gets very upset when leaving you |
|   | Seems overly friendly |  |  |   | Plays in a variety of ways |  |  |
|   | Seems timid, fearful or worries a lot |  |   | Knows how many fingers are on each hand |
|   | Acts much younger than their age |  |   | Seems unhappy, cries, whines |  |  |
|   | Counts three or more objects |  |   | Has trouble paying attention |  |  |
|   | Copies circles or other shapes |  |   | Seems overly aggressive |  |  |
|   | Tells when one object is lower or shorter |   | Points to or names the bigger of 2 objects |  |
|   | Prints first name or part of it |  |   | Seems clumsy, stumbles, falls, walks/runs poorly |
|   | Understands "one" or gives you just one when asked |  |  |  |  |
|   | Compares things, for example, says "this is bigger, heavier" |  |  |  |

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