**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" | | | | | |  |  |  | | |  | | |