

CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name: _____ M ___ F Birthdate: _____ Age _____

(For office use only)

MARSS other ID: _____ Languages spoken at home: _____

Parent/Guardian Name(s): _____

Person completing form: _____ Date: _____

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 | Child & Teen Check-ups | Child care center |
| Early Childhood Special Education | School-based pre-K | Family/neighbor care |
| Follow Along program | Private preschool | Library |
| Parenting Education | Head Start | WIC |
| Parks and Recreation programs | Foster Care | 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 breathing, 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 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.

Gets 60 minutes or more of exercise each day

Has difficulty falling/staying asleep

Is NOT able to/does NOT get 60 minutes of exercise

Takes a nap: from ____ to ____

____ TV/Video Game/Screen Time: hours per day

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 serving 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 detector carbon monoxide detector

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)