HEALTH & DEVELOPMENT HISTORY

Date Completed: ____________________________ **Person Completing:** ____

Child's Name: ☐ Male ☐ Female Date of Birth:

____ ___________________

Parent/Guardian Name: Home Phone: (   )

____ ______________________________

Who lives with your child? ____

Language(s) spoken in the home: ☐ English ☐ Other: ____

Health Insurance? ☐ Yes Provider: ______________________________ Group # ______________ ☐ No

Does your child live in a home built before: ☐ 1950 ☐ 1978 ☐ No

HEALTH HISTORY

1. Does your child seem well most of the time? ☐ Yes ☐ No
2. In the last year, has your child had 3 or more ear infections? ☐ Yes ☐ No
3. In the last year, has your child had more than 3 colds or sore throat infections with a fever? ☐ Yes ☐ No
4. Does your child have trouble getting rid of severe coughs? ☐ Yes ☐ No
5. Does your child complain frequently of headache, leg ache, stomachache, or other pain? ☐ Yes ☐ No
6. Has your child had trouble with his/her eyes or vision? ☐ Yes ☐ No
7. Is your child's appetite usually good? ☐ Yes ☐ No
8. Does your child chew unusual things such as pencils, window ledges, paint chips, or hair (PICA)? ☐ Yes ☐ No
9. Does your child have any trouble sleeping? ☐ Yes ☐ No

10. Has your child seen a dentist? (Date: _____________) If over 06 months, check No ☐ Yes ☐ No

12. Has your child had a "well check"? (Date: _____________) If over 12 months, check No ☐ Yes ☐ No

If yes, when: __________________ What for: ____

13. Is your child taking any medications? ☐ Yes ☐ No

If yes, what medication: ____ What for: _______________

14. Does your child take medicines (OTC), herbs, and/or vitamins? ☐ Yes ☐ No

List all: ____

15. List all food, medication, environmental allergies:

____

16. Past History—Circle any of the following your child has ever had:

Heart Trouble	Asthma	Birth Injury/Defect
Trouble Breathing at Birth	Diabetes	Describe: ____
Head Injury	Chickenpox	____
Convulsions, Seizures	Scarlet Fever	
Measles, Mumps, Rubella	Meningitis	Premature Birth
Kidney or Bladder Infection	Whooping Cough	How early? ____
Pneumonia	High Fever *	*(above 104 for 3 or more days) Date: ______________________________

17. Has your child had other illnesses, diseases, or diagnosis? ☐ Yes ☐ No

If yes, explain: ____

18. Has your child ever been hospitalized? ☐ Yes ☐ No

List all: ____

19. Has your child had any serious accidents or ingestions? ☐ Yes ☐ No

List all: ____

20. Does your child have any physical restrictions? ☐ Yes ☐ No

If yes, explain: ______________________________

21. Has your child ever been seen by a medical specialist other than a regular MD such as an OT, PT, SLP? ☐ Yes ☐ No

If yes, who: ____________ Reason: ______________________________

GROWTH AND DEVELOPMENT HISTORY

1. Does your child get along well with: (circle Y=yes and N=no)

Mother Y N Father Y N Brothers Y N Sisters Y N Other Children Y N Other Adults Y N

Comments: ______________________________

2. Eating habits: everyday my child eats some foods from these food groups: *(check all that apply)*

- ☐ Fruits (oranges, apples, bananas, mangos, tomatoes)
- ☐ Protein (beef, fish, poultry, peanut butter, legumes, eggs)
- ☐ Vegetables (spinach, corn peas, potatoes, cabbage)
- ☐ Grains (bread, cereal, rice, tortillas, pretzels, pasta)
- ☐ Dairy (milk, cheese, yogurt, tofu)
- ☐ Sweets & Fats (cookies, candy, fried foods, chips)

3. Every day, drinks: *(check all that apply)*

☐ Milk ☐ Juice ☐ Fruit Drinks ☐ Formula ☐ Kool-Aid ☐ Water ☐ Pop

4. My child is on a special diet. *(circle)* YES NO
   If yes, explain: ______________________________

5. My child drinks from: *(check all that apply)* ☐ Sippy Cup ☐ Regular Cup ☐ Bottle

6. My child eats with: *(check all that apply)* ☐ Fingers ☐ Spoon ☐ Fork

7. Is your child completely toilet trained? ☐ Yes ☐ No

8. Are you concerned about your child in any of the following areas: *(circle all that apply)*

Bedwetting	Wetting during the day	Difficulty going to bed or staying in bed	Bad dreams, wakefulness, disturbed sleep	Biting nails, nervous habits	Thumb sucking
Stammering or stuttering	Restlessness, over activity	Day dreaming, mind not on what he/she is doing	Irritability, easily upset, feelings hurt easily	Overly cautious, fearful, shy	Wanting too much attention, comfort, clinging
Breath holding	Contrary, stubborn, uncooperative, disobedient	Selfishness, inability to share	Jealously	Anger, temper tantrums	Destroying things on purpose
		Clumsiness, awkwardness	Too much concern about sex for age		

Comments: ______________________________

____

8. What experience has your child had with groups? (child care, preschool, Help Me Grow, Head Start, church or other)

____

Parent Signature: ______________________________ **Date:** ____________