Child Health and Developmental History

Date:_____ Child's Name:_____ Date of Birth:_____ Age:_____

☐Male ☐Female

Parent/Guardian Name:_____ Phone:_____

Address: _____ City:_____ Zip:_____

Language(s) spoken in your home:_____

# of doctor visits per year:_____ Clinic:_____ Physician:_____

Last eye exam: _____ Vision Provider:_____

# of dental visits per year:_____ Dental provider:_____

Family Information

Name	Relationship to the child	Last grade completed	Age	Living at home Yes	Living at home No	Male	Female

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

_____

_____

_____

Please describe your child's strengths:

Please check if you or your child participates in:

☐ Child and Teen Checkups ☐ Head Start

☐ Follow Along Program ☐ School Readiness

☐ WIC ☐Food Shelves

☐ Parent Education ☐ Early Childhood Family Education (ECFE)

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

☐Skin/bruising	☐Rashes	☐Eyes/Vision	☐Mouth	☐Teeth	☐Social (friends)
☐Walking/Balance	☐Learning	☐Behavior	☐Ears/Hearing	☐Talking	☐Nose
☐Feelings/Moods	☐Stomach	☐Toileting	☐Breathing/Coughing	☐Growth	☐Throat
☐Activity Level	☐Headaches	☐Health	☐Other		

Please check the boxes that apply to your child and explain:

☐Allergies to food and 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 at birth:_____
☐At birth, stayed in hospital longer than mother:_____
_____

Please check all boxes that describe your child:

☐Drinks from a cup
☐Drinks from a bottle
☐On a special diet

Please check the box if your child eats from these food groups daily:

☐Fruits (oranges, apples, bananas, mangoes, tomatoes)
☐Milk, cheese, yogurt, tofu
☐Meat, fish, poultry, peanut butter, beans, legumes, eggs
☐Vegetables (spinach, corn, peas, potatoes, cabbage
☐Bread, cereal, rice, tortillas, crackers, pasta
☐Cookies, cakes, candy, pie, butter, fried foods

Please check the box if your child drinks these beverages daily:

☐Milk ☐Juice ☐Fruit drinks ☐Pop/Soda
☐Formula ☐Kool-Aid ☐Water

Child's Daily Routines

Please answer the following questions about your child's habits and routines:

Sleep Pattern
☐My child goes to sleep easily
☐It is difficult for my child to fall asleep or stay asleep
☐My child goes to bed at _____PM
☐My child wakes up at _____AM
☐My child takes a nap from _____PM to _____PM
☐My child does not take naps any longer

TV viewing/ Screen time
☐My child watches TV _____hours a day
☐My child plays video games ____hours a day
☐My child is on the computer/internet ____hours a day

Exercise
☐My child gets 60 minutes or more of vigorous exercise per day
☐My child isn't able to get 60 minutes of exercise daily

Home/Safety

Please check all boxes that apply to your child:

Does your child live in a home or building:
☐built before 1950
☐built before 1978
☐Remodeled within the last 5 years

If so, has the child's blood lead level ever been checked? ☐Yes ☐No

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

☐Use tobacco ☐Use alcohol ☐Have a gun

Is your child exposed to:

☐Violence ☐Street drugs ☐Unsafe conditions
☐Abuse ☐Cigarette smoke

Do you have concerns/questions or want information about:

☐Seat belts/Car seats ☐Gun safety
☐Lead poisoning ☐Bike helmet/safety
☐Protective sports gear ☐Stranger safety
☐Toy/playground safety ☐TV watching
☐Emergency/hotline phone numbers
☐Child rearing/discipline ☐smoke detectors
☐Carbon monoxide detectors
☐Parenting ☐Food/clothing
☐Child development ☐Health or dental care
☐Adult education ☐Nutrition
☐Asthma ☐Recreational programs
☐Other

Nutrition

☐My child eats 3 or more servings of whole grains a day (whole wheat bread or pasta, brown rice, quinoa, whole oats, millet)
☐My child eats 5-9 servings of fruits and vegetables
☐My child eats 2-3 servings of iron-rich foods a day (legumes, fish, meat, eggs)
☐My child eats 3 servings a day of calcium-rich foods
☐My child eats more than 1 serving a day of sweets or junk food

Please check the boxes that apply to your child and explain as needed:

Prenatal: Age of mother during pregnancy_____
Regular prenatal care? ☐Yes ☐No
Month prenatal care began (1-9) _____

☐My child was born at term (37-42) weeks gestation.
☐My child was born early or late at _____ weeks gestation.

My child weighed _____pounds _____ounces at birth.

Is it possible that before you knew you were pregnant you:
☐Drank alcohol
☐Smoked cigarettes
☐Took prescription medication (list) _____
☐Used street drugs
☐Were exposed toxic chemicals (lead, mercury, PCBs, dioxin, fertilizers, pesticides)

Please check the following concerns you have about your child:

Thinking
☐Does not seem to understand; is slow to "catch on"
☐Unable to follow directions
☐Has trouble paying attention
☐Poor listener
☐Anxious/worries a lot
☐Fearful
☐Often seems unhappy
☐Overly sensitive, feelings easily hurt
☐Has not learned to do things at the same age as other kids

Behavior
☐Overly quiet
☐Highly active
☐Unable to control own behavior
☐Seems unhappy; overly cries, whines
☐Refuses to comply with rules
☐Angers easily
☐Destructive
☐Takes things that don't belong to him
☐Immature; acts younger than age
☐Temper tantrums
☐Easily frustrated
☐Sensory issues: over reacts to loud sounds, dirty hands touch, pain, or bright lights

Physical Problems
☐Breathing problems
☐Frequent headaches
☐Frequent stomach aches or poor appetite
☐Speech/language is difficult to understand
☐Bowel/bladder problem; not toilet trained
☐Daytime/nighttime toileting accidents
☐Feeding concerns

Social Interactions
☐Seldom plays with other children
☐Aggressive behavior; threatens or harms others
☐Overly shy
☐Seems overly friendly