# 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.

☐ Has difficulty falling/staying asleep

☐ Takes a nap: from ____to____

☐ Gets 60 minutes or more of exercise each day

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

_____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 ○ with friends or family ○ hotel or motel

○ emergency shelter/transitional housing

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

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

Other:_____

**Please check any of the following:**

☐ Says numbers 1 to 10

☐ Has trouble speaking or hard to understand

☐ Has trouble being understood by others

☐ Seems clumsy when using hands

☐ understands other people

☐ Able to follow directions

☐ Plays in a variety of ways

☐ Walks or runs poorly (falls)