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 (ECFE)	_____ Child &Teen Checkups	_____ Child Care Center
_____Early Childhood Special Education (ECSE)	_____ School Readiness	_____ Family/neighbor care
_____ Follow Along Program	_____ Private Preschool	_____ Library
_____ Parenting Education	_____ Head Start	_____ WIC
_____ Park and Rec programs	_____ Foster Care	_____ Food Shelf

HEALTH
Please check any concerns that apply to your child and describe:

_____ Allergies__ foods __ medicines ___animals/ insects __ 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 3 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 SAFTEY

Current housing situation: __ housed (rental or homeowner) __staying with friends or family
__staying in emergency shelter/transitional housing __ staying in hotel or motel

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 and safety equipment _____ smoke detector _____ carbon monoxide detector

LEARNING

_____ My child learned to do things at the same age as other children (sit, stand, walk, become 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)