

CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-5 YEARS)

Date Screening Completed: _____ Person Completing: _____

Child/Student MARSS ID or Record #: _____ (Office use only)

Child's Name: _____

Male _____ Female _____ Birthdate: _____ Age: _____

Parent/Guardian Name: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Who lives with your child? _____

Language (s) spoken in the home: _____

How often does your child see a doctor or a nurse? (number of visits per year) _____

How often does your child see a dentist? (number of visits per year) _____

Do you have health insurance? Yes _____ No _____

Insurance provider: _____ Group #: _____

Do you have questions or concerns about your child? We can talk about them today.

Please list concerns: _____

Please describe your child's special needs and strengths: _____

Select the programs or services you or your child use, if any.

Early Childhood Family Education (ECFE) _____ Child and Teen Checkups _____

Follow Along Program _____ Head Start _____ School Readiness _____

Parenting Education _____ WIC _____ Food Pantries _____

Select the areas in which you have concerns or questions related to your child, if any.

Health _____ Learning _____ Behavior _____ Talking _____ Growth _____ Eyes/vision _____

Skin/bruising, rashes _____ Ears/hearing _____ Nose _____ Throat _____ Teeth _____ Mouth _____

Stomach _____ Toileting _____ Activity level _____ Walking/balance _____ Social/friends _____

Feelings/moods _____ Breathing/coughing _____ Headaches _____ General appearance _____

Other _____

HEALTH

Please describe any of the following that pertain to your child.

Allergies to foods and/or 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 birth _____

At birth stayed in the hospital longer than mother _____

Members of the same family sometimes have the same health problems.

Please list family health problems: _____

EATING HABITS

Please check all that describe your child.

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

Every day he/she eats foods from these food groups:

Fruits (oranges, apples, bananas, mangos, tomatoes) _____

Vegetables (spinach, corn, peas, potatoes, cabbage) _____

Milk, cheese, yogurt, tofu _____

Meat, fish, poultry, peanut butter, beans, legumes, eggs _____

Cookies, cakes, candy, pie, butter, fried foods _____

Bread, cereal, rice, tortillas, crackers, pasta _____

Every day he/she drinks:

Milk _____ Juice _____ Fruit drinks _____ Formula _____ Kool-aid® _____ Water _____ Pop _____

HOME

Please check all that describe your child:

Does your child live/play in a home or building built before: 1950 _____ 1978 and is being remodeled _____

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

Use tobacco _____ Use alcohol _____ Have a gun _____

Is your child exposed to: Violence _____ Street drugs _____ Unsafe conditions _____

Do you have questions, concerns, or want information about:

- | | | |
|--|----------------------------|-----------------------------|
| Bike helmet/safety _____ | Emergency hotline _____ | Lead poisoning _____ |
| Stranger safety _____ | Carbon monoxide _____ | Phone numbers _____ |
| Parenting issues _____ | Severe weather plans _____ | Seat belts/car seats _____ |
| TV watching _____ | Child care _____ | Family relations _____ |
| Sleeping _____ | Crying _____ | Poisoning _____ |
| Teaching your child _____ | Child rearing _____ | Fire escape plan _____ |
| Smoke detectors _____ | Toilet training _____ | Gun Safety _____ |
| Protective sports gear _____ | Discipline _____ | Kindergarten _____ |
| Storing cleaning supplies/medication _____ | | Toy/playground safety _____ |

LEARNING

Please check all boxes that describe your child:

- | | |
|--|---|
| _____ Says numbers from 1 to 10 | _____ Seems clumsy when using hands |
| _____ Stutters, stammers | _____ Seems clumsy, stumbles, falls, walks or runs poorly |
| _____ Has trouble being understood | _____ Seldom plays with other children |
| _____ Understands other people | _____ Clings or gets very upset when leaving you |
| _____ Seems overly friendly | _____ Plays in a variety of ways |
| _____ Seems timid, fearful, or worries a lot | _____ Knows how many fingers are on each hand |
| _____ Acts much younger than age | _____ Seems unhappy, cries, whines |
| _____ Counts three or more objects | _____ Has trouble paying attention |
| _____ Copies circles or other shapes | _____ Seems overly aggressive |
| _____ Tells when one object is lower or shorter | _____ Has trouble sitting still |
| _____ Prints first name or part of it | _____ Points to or names the bigger of two objects |
| _____ Understands "one" or gives you just one when asked | |
| _____ Compares things, for example, says "this one is bigger, heavier" | |

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