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| **IDENTIFYING INFORMATION** |
| Age: Sex: Grade: School: |
| ADDRESS:  |
| This form is completed by: Relationship to Child: |
| Reason for assessment: |
|  Mother’s Phone: Home: Work: Cell: e-mail: |
|  Father’s Phone: Home: Work: Cell: e-mail: |
| Child lives with: Both Parents  Mother Father Other (explain)  |
| My chilas My child has the following health care coverage: Medicaid CHP+ Private None  |
| Child’s Primary Health Care Provider: Phone: |
| Date of last physical: Date of Last Visit: Reason for visit: |
| Child’ Dentist: Date of Last Dental exam: |

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| **PREGNANCY AND BIRTH** |
| Month into pregnancy that medical care began: Length of pregnancy:  |
| Were there any medications taken while pregnant? Explain: |
| Were there any complications with pregnancy? No Yes  Explain:  |
| Were there any complications with labor and delivery? No Yes  Explain: |
| Length of labor: Birth Weight: APGAR scores:  |
| Explain any health issues at birth: |
| Did baby require extra stay in hospital? No Yes  Explain: |

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| **DEVELOPMENTAL HISTORY** | Yes | No | Comments |
| Did your child crawl by 9 months?  |  |  |  |
| Did your child walk by 18 months?  |  |  |  |
| Did your child say words by 15 months?  |  |  |  |
| Was your child toilet trained by 3½ years?  |  |  |  |
| Were there problems with balance coordination?  |  |  |  |
| Were there problems with fine motor skills? (buttons, handwriting, picking something up)  |  |  |  |
| Do you have other concerns about your child’s development? (If yes, explain)  |  |  |  |

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| **ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND/OR ACCIDENTS** |
| Major Illnesses: ­­­­­­­­­­­­­­­­­­­ |
| Hospitalization/Surgeries:  |
| Accidents/Injuries:  |

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| **Body System History (Explain if “yes”)** | Yes | No | Comments |
| **Teeth**: Any Dental concerns?  |  |  |  |
| **Ears**: Any known hearing problems?  |  |  |  |
|  Do you have concerns about your child’s hearing? |  |  |  |
|  History of chronic ear infections? (PE tubes? Last infection?) |  |  |  |
| **Eyes**: Does your child have problems seeing? |  |  |  |
|  Does your child wear glasses? Contacts? Date of last exam? |  |  |  |
|  Name of Eye Specialist if has one: |
| **Cardiac:**  Does your child have any heart problems? |  |  |  |
|  Does your child fatigue easily or have poor endurance? |  |  |  |
| **Respiratory:** Does your child have any breathing problems? |  |  |  |
|  Is he/she prone to upper respiratory infections? |  |  |  |
|  Does your child have asthma? |  |  |  |
| **Gastrointestinal and Urinary**: Does child have any problems going to the bathroom? |  |  |  |
|  Bedwetting problems? |  |  |  |
|  Constipation problems? |  |  |  |
|  Difficult to train? |  |  |  |
|  Does your child have dietary/food needs or concerns? |  |  |  |
|  Do you have concerns about your child’s weight? |  |  |  |
|  Does your child have frequent stomach aches? |  |  |  |
| **Skeletal and Muscular:** Any broken bones? If yes, when, which bone(s) |  |  |  |
|  Does your child have any physical disabilities? |  |  |  |
|  Are there any restrictions for activity? |  |  |  |
| **Neurological:** Has your child ever had a seizure?  |  |  |  |
|  Does your child have frequent headaches? |  |  |  |
|  Has your child ever had a head injury or concussion? |  |  |  |
|  After injury: Dizziness?  Memory problems? Headaches?  Fatigue?  |  |  |  |
|  Did your child see a physician? Yes  No Hospitalized? Yes  No  |  |  |  |
|  Does your child have sleeping/bedtime concerns? |  |  |  |
|  Goes to bed school nights at \_\_\_\_\_\_\_\_ Gets up at \_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
|  TV in bedroom? Yes  No Computer in bedroom? Yes  No  |  |  |  |
|  Does your child snore? Yes  No  |  |  |  |
|  Does your child have a limited attention span? |  |  |  |
|  Do you think your child is distractible? |  |  |  |
|  Is your student impulsive? |  |  |  |
|  Do you have concerns about your child’s behavior or emotional status? |  |  |  |
| **Allergies**: Does your child have medication allergies? |  |  |  |
|  Food allergies? |  |  |  |
|  Insect allergies? (bee, wasp sting) |  |  |  |
|  Environmental allergies? |  |  |  |
|  Is your child seeing an allergist? (who/when) |  |  |  |
| **Medications**: Child currently taking medications? (prescription or over-the-counter) |  |  |  |
|  If yes, list medications, dose, and time taken |  |  |  |
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| HEALTHY LIFESTYLE |  |  |  |
| Does your child eat 5 fruits or vegetables a day? |  |  |  |
| Does your child limit TV or computer use to 2 hours per day outside of school? |  |  |  |
| Does your child get 1 hour of physical activity every day? |  |  |  |
| Does your child limit intake of sweet drinks? (sodas, juice, etc.)  |  |  |  |

Signature of person completing this form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_