



Child Developmental & Health History

Early Childhood Screening is a chance to learn about your child's health and development and get community resources before kindergarten. Completion of this form is voluntary. Declining to answer any questions will not prevent your child from enrolling in kindergarten. Please complete all pages of this form before your screening appointment and bring it with you. Thank you!

Child's Full Name _____ Date of Birth _____ Male Female

Parent's Name _____ Phone (home) _____

Phone (cell) _____ Phone (work) _____

Address _____ Language(s) spoken in the home _____

City & Zip _____

Please list persons living in the home, including adults and children:

| First and Last Name | Relationship to Child | Birthdate | Male or Female |
|---------------------|-----------------------|-----------|----------------|
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Have there been recent situational or environmental changes in your child's life? Please check all that apply.

Divorce/separation New baby Moved to new residence Change in guardianship Other _____

Please detail any information that you want screening staff to know about your family's cultural background and heritage (language, traditions) that might make a difference in the assessment of learning and/or behavior. _____

Check the boxes if you or your child use:

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| <input type="checkbox"/> Early Childhood Family Education | <input type="checkbox"/> Head Start | <input type="checkbox"/> Follow-Along Program |
| <input type="checkbox"/> Preschool — Location: _____ | <input type="checkbox"/> Adult Basic Education | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Childcare _____ | <input type="checkbox"/> Child and Teen Checkups | <input type="checkbox"/> Parenting Education |

Describe your child's strengths: _____

What are your main concerns for your child? Please check all that apply.

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| <input type="checkbox"/> Gross Motor (balance, coordination, running, walking) | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Fine Motor (writing, cutting, stacking blocks) | <input type="checkbox"/> Attention/Hyperactivity |
| <input type="checkbox"/> Adapting to changes in routine/environment | <input type="checkbox"/> Social Interactions |
| <input type="checkbox"/> Behavior (tantrums, aggression) | <input type="checkbox"/> Self Help (eating, dressing, toileting) |
| <input type="checkbox"/> Pre-Academics (counting, naming colors/shapes/letters) | <input type="checkbox"/> Other _____ |

Check the boxes if you have questions, concerns, or want information about:

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| <input type="checkbox"/> child care | <input type="checkbox"/> child development | <input type="checkbox"/> child rearing | <input type="checkbox"/> crying/whining |
| <input type="checkbox"/> discipline | <input type="checkbox"/> emergency/hotline numbers | <input type="checkbox"/> family relationships | <input type="checkbox"/> storing meds & cleaning supplies |
| <input type="checkbox"/> gun safety | <input type="checkbox"/> kindergarten/school | <input type="checkbox"/> personal safety | <input type="checkbox"/> lead poisoning |
| <input type="checkbox"/> seat belts/car seats | <input type="checkbox"/> severe weather/disaster plans | <input type="checkbox"/> teaching your child | <input type="checkbox"/> carbon monoxide |
| <input type="checkbox"/> toy/playground safety | <input type="checkbox"/> TV watching | <input type="checkbox"/> toilet training | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> fire escape plans | <input type="checkbox"/> bike/sports helmets | | |

Other questions or concerns: _____

When traveling in a car/vehicle, how often is your child in a car or booster seat? Never Sometimes Usually Always

Does your child wear a safety helmet when biking? Yes No My child does not ride a bicycle or tricycle

Check all boxes that describe your child:

Check the frequency that best describes your child in the areas below:

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| <input type="checkbox"/> Says numbers from 1 to 10 | Hits or takes toys from others | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Copies a circle or other shapes | Has trouble paying attention | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Follows two-step verbal directions | Seems overly aggressive | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Prints first name or part of it | Clings or gets very upset when leaving parent/caregiver | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Understands "one", gives you just one when asked | Prefers to play alone rather than with other children | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Can feed self independently, using utensils | Has difficulty in switching activities or places | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Plays in a variety of ways | Only likes certain foods; e.g. picky eater, unusual combinations | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Knows how many fingers are on each hand | Uses toys in unusual ways; e.g. lines up toys rather than playing with them | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Compares things, for example, says "This one is bigger, etc." | Destroys or damages things on purpose | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Can hold and use markers, pencils, scissors | Has specific interest or behavior that preoccupies or is unusual in its intensity | <input type="checkbox"/> seldom/never | <input type="checkbox"/> sometimes | <input type="checkbox"/> usually/always |
| <input type="checkbox"/> Has balance and control when walking, hopping, running | | | | |
| <input type="checkbox"/> Has trouble sitting still | | | | |
| <input type="checkbox"/> Seems quiet/withdrawn | | | | |
| <input type="checkbox"/> Has unusual fear of _____ | | | | |
| <input type="checkbox"/> Has difficulty forming good relationships with peers/adults | | | | |
| <input type="checkbox"/> Acts much younger than age | | | | |
| <input type="checkbox"/> Seldom plays with other children | | | | |
| <input type="checkbox"/> Seems unhappy, cries, whines | | | | |
| <input type="checkbox"/> Seems more active than other children his/her age | | | | |
| <input type="checkbox"/> Seems bothered by certain textures; e.g. food, clothing | | | | |

When your child becomes very frustrated or upset, what does he/she do?

Cries Screams Hits others Hits self Pushes Other _____

Length of outbursts: Less than 15 minutes 15 to 45 minutes 45 minutes or longer

Frequency of outbursts: Daily Weekly Monthly

Please check the box that best describes your child's communication skills.

- I can understand what my child says.
 Never Sometime Usually Always
Estimated percentage of language that you can understand: _____%
- My child understands what I say.
 Never Sometimes Usually Always
- When I ask a question, my child gives an answer that corresponds to that question.
 Never Sometimes Usually Always
- My child uses sentences of 3-5 words in length.
 Never Sometimes Usually Always
- My child will listen to at least part of a storybook that is at his/her level of understanding.
 Never Sometimes Usually Always
- I am concerned that my child could be stuttering/stammering.
 Always Usually Sometimes Never
If so, have you noticed repetitions or prolongations of sounds/words for more than 3 months? Yes No
If so, is there family history of stuttering/stammering? Yes No
- I am concerned about my child's voice quality (nasal, hoarse). Yes No
- I am concerned about my child's speech & language development. Yes No

Provide any additional information about your child's speech and language that you feel would be helpful:

Health History



Child's Name _____

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| HEALTH INSURANCE/ HEALTH CARE | Do you have health insurance for your child? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Name of plan _____ Medical Assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | Would you like information about MN Care insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | How often does your child see: a healthcare provider? _____ a dentist? _____ |
| | Last well-child check up _____ Last dental visit _____ |

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| FAMILY HISTORY | Have any of your child's blood relatives (parents, grandparents, siblings, uncles, aunts) had any of the following? Check all that apply and write the relative in the blank: |
| | <input type="checkbox"/> ADD/ADHD _____ <input type="checkbox"/> Cystic Fibrosis _____ <input type="checkbox"/> Epilepsy (seizures) _____ |
| | <input type="checkbox"/> Allergy/Hay Fever _____ <input type="checkbox"/> Depression/Anxiety _____ <input type="checkbox"/> Growth Problems _____ |
| | <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Diabetes (juvenile) _____ <input type="checkbox"/> Migraines _____ |
| | <input type="checkbox"/> Autism _____ <input type="checkbox"/> Emotional Disorders _____ <input type="checkbox"/> Reading Problems _____ |

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| PREGNANCY/ BIRTH | When my child was born: |
| | <input type="checkbox"/> There were difficulties during pregnancy, labor or delivery. Explain: _____ |
| | <input type="checkbox"/> My child had difficulties at birth or shortly after birth. Explain: _____ |
| | <input type="checkbox"/> My child weighed _____ at birth. Medications taken during pregnancy: _____ |
| | <input type="checkbox"/> My child did not go home from the hospital with the mother. Reason: _____ |
| <input type="checkbox"/> My child is adopted. Age at adoption: _____ | |

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| GROWTH & DEVELOPMENT | I have been and/or am currently concerned about my child's development. <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | If Yes, please explain: _____ |

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| CHILDHOOD ILLNESSES | My child has had the following diseases: |
| | <input type="checkbox"/> Meningitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Strep Infections/Scarlet Fever |
| | <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> Chicken Pox |
| | <input type="checkbox"/> Mumps <input type="checkbox"/> Whooping Cough <input type="checkbox"/> High Fever (104° for 2 days) |
| | <input type="checkbox"/> Has had a serious illness. Explain: _____ |
| | <input type="checkbox"/> Has been hospitalized. Include date(s) and reason(s): _____ |

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| ALLERGIES | My child has the following allergies or has had a reaction to: |
| | <input type="checkbox"/> Insect Stings <input type="checkbox"/> Latex <input type="checkbox"/> An immunization _____ |
| | <input type="checkbox"/> Plants <input type="checkbox"/> Dust <input type="checkbox"/> A medication _____ |
| | <input type="checkbox"/> Mold <input type="checkbox"/> Animals <input type="checkbox"/> Food _____ |
| | List reaction: _____ Does your child require an Epi pen? <input type="checkbox"/> No <input type="checkbox"/> Yes |

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| INJURIES | <input type="checkbox"/> My child has had a serious injury. Explain: _____ |
| | <input type="checkbox"/> My child has been poisoned <input type="checkbox"/> We have the Poison Control number at home (800-222-1222) |

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| SPECIAL HEALTH NEEDS | My child: |
| | <input type="checkbox"/> Has had special tests for health or emotional problems. Explain: _____ |
| | <input type="checkbox"/> Has been seen by a health specialist. Explain: _____ |
| | <input type="checkbox"/> Has chronic health problems. Explain: _____ |
| <input type="checkbox"/> List any medication(s) or herbs your child takes regularly: _____ | |

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| HOME | Does your child spend time in a home built before: <input type="checkbox"/> 1950 <input type="checkbox"/> 1978 <input type="checkbox"/> home has been remodeled |
| | Does anyone in your home or who cares for your child: <input type="checkbox"/> use tobacco <input type="checkbox"/> use alcohol |
| | Do you have any guns in your home? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, are the guns locked? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Is your child exposed to: <input type="checkbox"/> violence <input type="checkbox"/> street drugs <input type="checkbox"/> unsafe conditions |
| | Do you feel safe in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Check here if you would like to talk about safety <input type="checkbox"/> |

Please check all the boxes that pertain to your child:

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| HEAD | <input type="checkbox"/> Has had a head injury <input type="checkbox"/> Has had a period of unconsciousness as a result of an injury. Explain: _____ | <input type="checkbox"/> Has headaches <input type="checkbox"/> Complains of dizziness |
| EYES | <input type="checkbox"/> Has problems with eyes <input type="checkbox"/> Eyes cross or wander separately <input type="checkbox"/> Do you have concerns about your child's vision? Explain: _____ | <input type="checkbox"/> Wear glasses <input type="checkbox"/> Crusty lids <input type="checkbox"/> Squinting/Blinking <input type="checkbox"/> Mattering of eyes |
| EARS, NOSE, THROAT | <input type="checkbox"/> Failed newborn hearing screening <input type="checkbox"/> Has had ear problems two or three times within a year <input type="checkbox"/> Has had earaches or discharge from the ear within the past six months <input type="checkbox"/> Seems to have trouble hearing <input type="checkbox"/> Has had ventilation (PE) tubes put in ears. More than once <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Has two or more throat infections in a year <input type="checkbox"/> Has frequent nose bleeds <input type="checkbox"/> Has swollen glands frequently |
| DENTAL | Receives fluoride from the following sources: <input type="checkbox"/> Vitamins <input type="checkbox"/> Toothpaste <input type="checkbox"/> Tablets/Drops <input type="checkbox"/> Mouth Rinses <input type="checkbox"/> Dental Office <input type="checkbox"/> Has trouble with teeth, gums, mouth, or lips. Explain: _____ <input type="checkbox"/> Has had dental sealants placed on one or more teeth <input type="checkbox"/> Brushes teeth daily <input type="checkbox"/> Has had a tooth chipped or damaged in any way <input type="checkbox"/> Drinks from a bottle | |
| RESPIRATORY | <input type="checkbox"/> Has had six to ten colds in one year <input type="checkbox"/> Has a barky cough with colds <input type="checkbox"/> Cough or colds last longer than two weeks | <input type="checkbox"/> Has shortage of breath, asthma, or wheezing at times <input type="checkbox"/> Has been exposed to tuberculosis |
| CARDIO-VASCULAR | <input type="checkbox"/> Hands and feet turn blue <input type="checkbox"/> Have been told my child has a heart murmur | <input type="checkbox"/> Has heart trouble <input type="checkbox"/> Seems to tire easily |
| GASTRO-INTESTINAL | <input type="checkbox"/> Has trouble with constipation <input type="checkbox"/> Has diarrhea frequently <input type="checkbox"/> Vomits frequently <input type="checkbox"/> Problems with foods disagreeing with him/her. Special diet: _____ | <input type="checkbox"/> Has frequent stomach aches <input type="checkbox"/> Has bloody stools <input type="checkbox"/> Has anal itching |
| URINARY | <input type="checkbox"/> Is toilet trained <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Has frequent accidents during the day | <input type="checkbox"/> Urinates frequently <input type="checkbox"/> Has foul smelling urine |
| SKELETAL/SKIN | <input type="checkbox"/> Complains of pain in arms, legs, back or joints <input type="checkbox"/> Has/had braces or corrective shoes <input type="checkbox"/> Limps, toes in or toes out, bow legged | <input type="checkbox"/> Bruises easily <input type="checkbox"/> Has frequent rashes or eczema <input type="checkbox"/> Has unexplained lumps or spots |
| NEURO-MUSCULAR | <input type="checkbox"/> Loses balance in unusual ways <input type="checkbox"/> Has a weakness in his/her body <input type="checkbox"/> Has staring spells <input type="checkbox"/> Is clumsy and awkward | <input type="checkbox"/> Has unexplained movements or jerk <input type="checkbox"/> Seems to fall down frequently <input type="checkbox"/> Has had convulsions or seizures Date of last seizure: _____ |
| EATING HABITS | Most days my child eats these foods: <input type="checkbox"/> Fruit <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat, Fish, Peanut Butter, Beans, Eggs | <input type="checkbox"/> Bread, Cereal, Rice, Pasta, Tortillas <input type="checkbox"/> Milk, Cheese, Yogurt, Tofu <input type="checkbox"/> Cookies, Cakes, Candy, Pie, Butter <input type="checkbox"/> Soda <input type="checkbox"/> Juice/Kool-aid |
| SLEEP HABITS | Night fall asleep time: _____ Morning wake up time: _____ Total sleep time: _____ <input type="checkbox"/> Snores <input type="checkbox"/> Awakes during night Length of naps daily: _____ | |
| OTHER | Describe any physical limitations or restrictions your child has: _____ Describe any health concerns you have about your child: _____ | |

This family information can be part of the child's school record: YES NO

Signature of Parent/Guardian: _____ Date: _____