WEST CENTRAL MINNESOTA Communities Action

CHILD HEALTH AND DEVELOPMENTAL HISTORY (Birth-5 YEARS)

Child's Name:_____ ☐ M ☐ F Birthdate:_____ Age_____

Parent/Guardian Name(s): _____ Date: _____

Date of last well child visit: _____ Date of last dental visit: _____

Does your child have health insurance? ☐ Yes ☐ No ☐ Applied

Please check the services you or your child have used:

☐ Food Shelf ☐ Child & Teen Checkups ☐ Childcare Center ☐ WIC

☐ School based Pre K ☐ Family/Neighbor Care ☐ Head Start

☐ Follow Along Training ☐ Foster Care/Adopted ☐ Early Childhood Family Education

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

*Indicates a Child Allergy Information form is needed

☐ *Allergies ☐ Food ☐ Medicine ☐ Animal/Insect ☐ Dust/Mold ☐ Seasonal _____

☐ Takes medication for a health condition: ☐ Yes ☐ No

☐ Visits to a health specialist, hospital stay and/or surgeries: _____

☐ Serious injuries or loss of consciousness: _____

☐ Trouble breathing, coughing or asthma: _____

☐ Skin or rash problems: _____

☐ Active or history of seizures: _____

☐ Wears glasses or has vision problems: _____

☐ Ear or hearing problems: _____

☐ Teeth or mouth problems: _____

☐ Eating, stomach concerns or constipation: _____

☐ Mental health concerns like anxiety, depression, or attention issues: _____

☐ Problems during pregnancy or birth: _____

☐ Born more than three weeks early or late: # of weeks at birth _____

Please check any Family Health problems (child's parents or siblings):

☐ Attention issues ☐ Vision ☐ Learning ☐ Mental health disorders ☐ Deafness/Hearing

CHILD'S DAILY ROUTINE

Sleeps at ____p.m. Wakes at _____a.m. ☐ Difficulty falling or staying asleep

☐ Gets 60 minutes or more of exercise each day

Every day eats some foods from the food groups:

☐ 5-9 servings of fruits or vegetables: oranges, apples, bananas, mangos, spinach, corn, peas

☐ 3 servings of calcium rich foods: milk, cheese, yogurt, eggs

☐ 2-3 servings of iron rich foods: fish, poultry, meat, beans, legumes, eggs

☐ 3 or more servings of whole grains: cereal, brown rice, tortillas, crackers, pasta, wheat bread

HOME SAFETY

Does your child live or play in a home or building built before: ☐ 1978 or that's been ☐ remodeled in the last 5 years?

Does anyone at home or who cares for your child: ☐ use tobacco/smoke ☐ use alcohol ☐ have a gun (use safety lock)

Do you have concerns that your child is exposed to: ☐ violence ☐ street drugs ☐ unsafe conditions

LEARNING

Please check any of the following:

☐ Says numbers 1 to 10 ☐ Hard to understand ☐ Seems clumsy when using hands

☐ Understands other people ☐ Plays in a variety of ways ☐ Child is nonverbal

☐ Current Individual Education Plan (IEP)

Parent/Guardian Signature: _____ **Date:** _____