Child Development History

Date of screening__________ Person completing paperwork:_______________________________________

Consolidated forms with questions from the ESI-R and Child Development History (3-5 years)

<table>
<tr><td rowspan="2">Child's name</td><td>Female</td><td></td><td rowspan="2">Birthdate</td><td rowspan="2">Age</td><td rowspan="2">(For office use only)Child/Student MARRS ID or Record number</td></tr>
<tr><td>Male</td><td></td></tr>
<tr><td colspan="4">Address</td><td colspan="2">Phone</td></tr>
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City	Zip		Language(s) spoken in home?
Parent/Guardian name	Occupation	Phone number	Address (if different than child)
Parent/Guardian name	Occupation	Phone number	Address (if different than child)

Who lives with your child? Name/relationship ___________________________________age__________
Name/relationship ___________________________________age__________
Name/relationship ___________________________________age__________
Name/relationship ___________________________________age__________

How often does your child see a doctor or nurse?_____ How often does your child see a dentist?_____

Do you have health insurance?______ Insurance provider_______________________________________

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

Please list concerns/questions?____

____

Please check the boxes if you or your child use:					
	Follow-along program		Head Start		School Readiness
	(ECFE) Early Childhood Family Education		Child & Teen Checkups		Food Pantries
	WIC		Parenting Education		Child care

Other, please specify____

Preschool/childcare history	**Yes**	**No**
Has your child been in preschool/childcare before?		
If yes, for how long?		
Name of child's present or most recent school:		

Medical History - Birth		
Were there any significant problems during pregnancy?	**Yes**	**No**
Was your child more than 3 week premature?		
If yes, how many weeks premature?		**Weeks**
Baby's birth weight	**lbs.**	**oz.**
Did the baby stay in the hospital longer than the mother?		
At the time of birth, did the baby have seizures?		
At the time of birth, did the baby turn blue?		

If yes to any, please explain:____

Child's health since birth		
Eyes	**Yes**	**No**
Has your child ever had trouble seeing?		
Does your child hold books and objects close to his or her face?		
Have your child's eyes ever looked crossed?		
Have you ever suspected that your child has vision problems?		

If yes to any, please explain:____

Ears	Yes	No
Has your child had frequent ear infections?		
Has your child ever had trouble hearing?		
Have you ever suspected that your child has hearing problems?		

If yes to any, please explain:____

Coordination	Yes	No
Has your child ever had trouble walking, climbing, reaching, holding on to things?		

If yes, please explain:____

	Yes	No
Has your child had any significant injuries/surgeries/hospitalizations?		
Does your child have allergies?		
Is your child currently on any medications?		

If yes to any, please describe:____

Please describe any other health concerns:____

Nutrition		Yes	No
Does your child drink from a cup?			
Does your child have a special diet?			
Does your child eat foods from the following categories in a daily basis?	Fruits		
	Vegetables		
	Milk, cheese, yogurt, tofu		
	Meat, fish, poultry, peanut butter, legumes, eggs		
	Bread, cereal, rice, tortillas, crackers, pasta		
	Cookies, cakes, candy, pie, butter, fried foods		
Check beverages your child drinks every day -			

	Milk		Formula		Juice		Fruit drinks		Kool-aid		water

Please describe any nutrition concerns:____

Child's Development **Can you child-**	**Yes**	**No**
Feed him/herself using a spoon and/or fork?		
Wash and dry his/her own hands?		
Help with dressing or dress with a little assistance?		
Stay with a babysitter?		
Speak so that he/she can be understood by others?		
Express his/her thoughts and needs easily?		
Is your child-	**Yes**	**No**
Highly active		
Very quiet?		
Toilet trained during the day?		
In need of help with toileting?		
Do you have any concerns about your child's sleeping habits?		

Please describe any concerns you have about your child's development and/or activity level:___________

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Does your child -	**Yes**	**No**
Use crayons and/or markers to scribble or draw?		
Listen to stories being read?		
Play with blocks, boxes, cups or other construction toys without help?		
Turn the pages of a book and look at pictures?		
Recall stories and/or events?		
Enjoy playing alone or with imaginary friends?		
Talk with your friends/relatives who come to visit?		
Follow simple, age-appropriate directions?		
Does your child have opportunities to play with other children?		
Does your child turn up the volume very high?		
Does your child sit very close to the TV?		
How many hours a day does your child spend watching TV, playing on a phone, tablet, computer?	hours	

What are your child's favorite activities?____

____

Please describe any learning concerns:____

	Yes	**No**
Does your child live or play in a home built before 1950?		
Does your child live or play in a home built before 1978 and is being remodeled?		
Is your child exposed to guns?		
Is your child exposed to violence?		
Is your child exposed to unsafe conditions?		
Does anyone in your home who cares for your child use tobacco?		

Does anyone in your home who cares for your child use alcohol?		
Does anyone in your home who cares for your child have a gun?		

Do you have questions, concerns, or want information about:									
	Bike helmet safety		Emergency/hotline phone numbers		Lead poisoning		Seat belts/car seats		Stranger safety
	Carbon monoxide		Family relations		Other child rearing issues		Severe weather plans		TV watching
	Child care		Fire escape plans		Poisoning (syrup of ipecac)		Sleeping		Teaching your child
	Child rearing		Gun safety		Protective sports gear		Smoke detectors		Toilet training
	Crying		Kindergarten				Storing cleaning supplies/medications		Toy/playground safety
	Discipline								

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

Are there other things you would like to tell us about your child? ________________________________

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