HEALTH HISTORY

Early Childhood Screening (ECS)

Child's Name _____ **Birthdate** _____

HEALTH CARE	Physician/Health Care Provider _____ Date of last physical _____ Dentist _____ Date of last dental _____ Does your child have health insurance? ☐No ☐Private Insurance ☐MA or MN Care ☐Other_____
EYES/VISION	☐Has problems with eyes (squinting, crusty lids, mattering) ☐Eyes turn in or out ☐Tilts head to see ☐Eyes cross or wander separately ☐Holds items close to eyes ☐Wears glasses ☐Has had eye surgery ☐I have concerns about my child's vision. Explain _____ Eye Doctor (if applicable) _____ Date of last vision check _____
EARS/HEARING	☐Has had ear problems 2-3 times within a year ☐Speaks loudly ☐Says "what?" often ☐Has had earaches or discharge from the ear within the past 6 months ☐Seems to have trouble hearing ☐Has had ventilation (PE) tubes in ears ☐Other _____ Eye, Nose & Throat Doctor (if applicable) _____
MENTAL HEALTH	Has your child been diagnosed or do you have concerns with the following: ☐Autism ☐Depression ☐Anxiety ☐ADD/ADHD ☐Learning delays ☐Other ☐Mental health (explain) _____ Mental Health Provider (if applicable) _____
HAS YOUR CHILD HAD:	☐Seizures ☐Strep Throat ☐Heart Disease ☐Asthma ☐Eczema, Hives, Rashes ☐Pneumonia ☐Diabetes ☐Chicken Pox ☐Other PLEASE LIST: Diagnoses _____ Serious accidents (falls, head injury, poison, etc) _____ Hospitalizations _____ Surgeries _____ Seen by a Specialist _____ Medications that your child takes regularly _____

Check (√) all that apply to your child

FAMILY HISTORY	☐Child is adopted and I have no past health information for this child. Date of adoption _____ Have any of your child's blood relatives (parents, brothers, sisters, grandparents, aunts, uncles) ever had any of the following? ☐Allergy or Hay Fever ☐Diabetes ☐Eye Abnormalities ☐Cancer ☐Asthma ☐Epilepsy (seizures) ☐High Blood Pressure ☐Heart Problems ☐Cleft lip or palate ☐Reading problems ☐Growth Problems ☐Learning Disabilities ☐Deafness ☐Mental Health Issues ☐Drug or Alcohol Problems ☐Other _____
PREGNANCY & BIRTH	Birth weight ____ lbs. ____ oz. ☐Mother had health problems during pregnancy. ☐Saw physician fewer than 2 times during pregnancy. ☐There were difficulties during labor and/or delivery. ☐Child was more than three weeks early or late. ☐Child had difficulties at birth. ☐Child had problems in the first week. Mother used the following during pregnancy. If yes, indicate which trimester(s): 0-3 months 4-6 months 7-9 months ☐Prescription Medication ☐ ☐ ☐ ☐Alcohol ☐ ☐ ☐ ☐Marijuana ☐ ☐ ☐ ☐Cigarettes/Tobacco ☐ ☐ ☐ ☐Street Drugs ☐ ☐ ☐ ☐Other ☐ ☐ ☐
GASTRO-INTESTINAL	☐Vomits frequently ☐Has diarrhea frequently ☐Other _____ ☐Has frequent stomach aches ☐Has trouble with constipation

CARIO-VASCULAR	☐Hands and fingers turn blue ☐Has known heart trouble ☐Other _____ ☐Seems to tire easily ☐Diagnosed with heart murmur
NEURO-MUSCULAR	☐Loses balance in unusual ways ☐Has unexplained movements or jerks ☐Has staring spells ☐Has had seizures ☐Has weakness in the body ☐Had a concussion or head injury ☐Is clumsy and awkward ☐Falls down more than other children ☐Other _____
URINARY	☐Is not toilet trained ☐ Has trouble wetting during the day ☐Other _____ ☐Has trouble with bed wetting ☐Had had kidney or bladder infection
SKELETAL	☐Complains of pains in arms, legs, back ☐Has broken a bon ☐Limps, toes in or out ☐Wears braces or orthotics
DENTAL	Sources of water at home ☐city ☐private well ☐rural water system ☐other ☐don't know Receives fluoride from the following sources: ☐vitamins ☐toothpaste ☐tablets/drops ☐mouth rinses ☐dental office treatment ☐Teeth are brushed daily ☐Has dental sealants ☐Has had a toothache ☐Has chipped or damaged teeth ☐Has trouble with teeth, gums or mouth. Explain _____
LEAD POISONING RISKS	☐Child lives in or regularly visits a house that was built before 1950. ☐Child lives in or regularly visits a house built before 1978 with ongoing remodeling. ☐Child has a sibling or playmate who had or did have lead poisoning. ☐Child has had a blood lead test. Results ☐Child receives services such as: ☐MA ☐WIC ☐Head Start
NUTRITION	☐Child eats well ☐Child is very picky eater and lacks in: ☐Dairy ☐Protein ☐Fruits/Vegetables ☐Breads/Grains

Check (√) all that apply to your child

SOCIALIZING	☐Child is interested in playing with other children ☐Child plays pretend ☐Child can maintain play without issues with 1 or 2 peers ☐Child can maintain group play ☐Child can focus on one activity at a time
BEHAVIOR	☐Breaks things (destructive) ☐Has tantrums ☐Tests limits ☐ Is uncooperative ☐ Resists rules ☐Is easily distracted ☐Clings to an adult ☐Worries a lot ☐ Is fearful ☐Darts around ☐Shows anger ☐Shows aggression ☐Self harms ☐ Lines up toys ☐Persists when asked to stop ☐Has trouble staying at task ☐ Flaps hands, spins or exhibits other repetitive behavior

Check (√) if your child is struggling with the following:

SELF HELP	☐Toileting ☐Eating ☐ Following routines ☐Dressing ☐Securing fasters, buttons, zippers
SLEEPING	☐Difficulties falling asleep ☐Gets less than 8-10 hours of sleep a night ☐ Takes melatonin ☐Wakes up often ☐Naps Daily
MOTOR SKILLS	☐Walking without tripping ☐Using pencils and crayons ☐Catching a ball ☐Playing safely at park ☐Cutting with scissors
COMMUNI-CATION	☐Being understood when talking ☐Answering questions ☐Communicating wants ☐Talking in sentences ☐Following directions ☐Using words

At what age did your child:

Sit without support _____
Walk _____
Crawl _____
Get dressed without help _____
Talk in sentences _____
Become toilet trained _____

Preschool Experience (list site if applicable)

☐ECFE _____
☐ECSE _____
☐Daycare (family structured) _____
☐Structural Preschool _____
☐Head Start _____
☐Sunday School _____
☐None

Parent concerns not listed:

_____

_____

_____