

Form 17

DEVELOPMENTAL HEALTH HISTORY

Child's name _____
(Last) (First)

Birth date ____/____/____

Nickname _____

Physical Health

What health problems has your child had in the past? _____

What health problems does your child have now? _____

Other than what you listed above, does your child have any allergies? If so, to what? _____

How severe? _____

Does your child take any medicine regularly? If so, what? _____

Has your child ever been hospitalized? if so, when and why? _____

Does your child have any recurring chronic illness or health problem (such as asthma or frequent earaches)? _____

Does your child have a disability that has been diagnosed (such as cerebral palsy, seizure disorder, developmental delay)? _____

Do you have any other concerns about your child's health? _____

Development (compared with other children this age)

Does your child have any problems with talking or making sounds? Please explain. _____

Does your child have any problems with walking, running, or moving? Please explain. _____

Does your child have any problems seeing? Please explain. _____

Does your child have any problems using her or his hands (such as with puzzles, drawing, small building pieces)? Please explain. _____

Daily living

What is your child's typical eating pattern? _____

Write N/A (non applicable) if your child is too young for the following questions to apply:

What foods does your child like? _____

Dislike? _____

How well does your child use table utensils (cup, fork, spoon)? _____

How does your child indicate bathroom needs? Word(s) for *urination*: _____

Word(s) for *bowel movement*: _____

Special words for body parts: _____

What are your child's regular bladder and bowel patterns? Do you want us to follow a particular plan for toilet training? _____

For toddlers, please describe the use of diapers or toileting equipment at home (such as a potty, toilet seat adapter) _____

What are your child's regular sleeping patterns?

Awakes at _____ Naps at _____ Goes to bed at _____

What help does your child need to get dressed? _____

Social relationships/play

What ages are your child's most frequent playmates? _____

Is your child friendly? _____ Aggressive? _____ Shy? _____ Withdrawn? _____

Does your child play well alone? _____

What is your child's favorite toy? _____

What frightens your child? (Circle all that apply.) Animals? Rough children? Loud noises? The dark? Storms? Anything else? _____

Who does most of the disciplining? _____

What is the best way to discipline your child? _____

With which adults does your child have frequent contact? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)? _____

Parent's signature _____

Date _____