DEVELOPMENTAL HEALTH HISTORY
(Infants and Young Children)

Child's Name_____DOB_____

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 problems such as:

_____asthma ____cerebral palsy ____developmental delay

____diabetes ____frequent earaches ____hemophilia

____seizure disorder other_____

If medically diagnosed, what is the name of the doctor who diagnosed the illness or health problem.

_____

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

_____

_____

DEVELOPMENT (compared to 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 hearing? Please explain._____

_____

Does your child have any problems using her or his hands (such as with puzzles, 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 toileting?_____

_____

For toddlers, please describe use of diapers of toileting equipment (such as potty, toilet seat adapters)._____

_____

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Withdrawn?_____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?_____
Is your child frightened by (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, EXCLUDING physical punishment?
_____
With which adults does your child have frequent
contact?_____
_____
Does your child use a special comforting item(such as a blanket, stuffed animal, doll)?_____
Is there any other information that you wish to share that would assist in meeting your child's needs?_____
_____
Parent's Signature_____
Date_____

Note: The content of this form is taken from "Healthy Young Children A Manual for Programs", a publication of the National Association for the Education of Young Children, and used by permission. NAEYC, 1509 16th Street, N.W., Washington, D.c. 20036-1426 (202)-232-8777 (800)-424-2460 FAX (202)-328-1846