Health Questionnaire

Child's Name _____ Birth Date_____ Age _____ Sex _____

Parent/Guardian _____ Address _____
(street or P.O. Box)

_____
(city)(Zip)

Phone No. _____

Health History

	Yes	No
Did your child weigh less than 5 lbs. at birth?	___	___
Has your child had any illness with high fever? (104 longer than 2 days)	___	___
Has your child been hospitalized since birth for any reason?	___	___
If yes, state reason. _____		
Does your child take medication regularly?	___	___
If yes, what medication? _____		
Does your child have regular medical check-ups?	___	___
If so, from whom? _____		

Immunizations

Directions: Write date on each line or attach an immunization record copy. If family chooses not to immunize write NI.

	DTaP (DPT)	PCV	Influenza	Hib	IPV (Polio)	HepB	MMR	Varicella (Chicken Pox)
DOSE 1								
DOSE 2								
DOSE 3								
DOSE 4								
DOSE 5								

KEY:

DTaP—Diptheria, Tetanus, & Pertussis vaccines
PCV—Pneumococcal conjugate vaccine
Influenza
Hib—Haemophilus influenzae type b vaccine
IPV—Inactivated Poliovirus
HepB—Hepatitus B vaccine
MMR—Measles, Mumps, & Rubella vaccines
Varicella—Chicken Pox vaccine

General Development

What things can your child do very well?

What things are challenging for your child?

What concerns do you or someone else have about your child's general growth and development?

What concerns do you or someone else have about your child's behavior?

Dental

Directions: Circle Y or N

Does anything appear abnormal (swelling, redness, apparent decay) on the child's teeth or gums? Y N

If yes, please describe.

Is brushing teeth a part of your child's daily routine? Y N

Vision

Directions: Circle Y or N

Has your child ever had a vision check by a doctor? Y N

When? _____ By whom? _____

Results? _____

A yes answer for any item #1-12 indicates the need for discussion and follow-up.

1. Eyes crossed—turning in or out—at any time, or eyes that do not appear straight, especially when child is tired	Y N
2. Has reddened eyes or eyelids	Y N
3. Has encrusted eyelids	Y N
4. Has frequent sties (pimple on the eyelid)	Y N
5. Eyes appear to move more than other people's eyes do	Y N
6. Eyelids droop	Y N
7. Has white spots or cloudiness covering some or all of the center of the eye	Y N
8. Complains of burning, itching, or pain in eyes	Y N
9. Stares at bright lights frequently or repeatedly flicks objects in front of face	Y N
10. Is bothered by light more than you are	Y N
11. The pupil, dark center part of the eye, seems larger or smaller than the pupil in other children's eyes	Y N
12. Complains of headache or nausea	Y N

A yes answer for 3 or more items #13-25 indicates the need for discussion and follow-up.

13. Has watery eyes	Y N
14. Complains of tired eyes; rubs eye often	Y N
15. Moves the head forward or backward while looking at distant objects	Y N
16. Turns the head to use one eye only (closes or covers one eye)	Y N
17. Tilts the head to one side often, or all the time	Y N
18. Places an object close to the eyes to look at it	Y N
19. Squints while looking at objects	Y N
20. Blinks more than you do	Y N
21. Has difficulty walking or running; trips over objects more often than others do	Y N
22. Unable to see distant objects	Y N
23. Seems to see better during the day than at night	Y N
24. Is unable to stack blocks or other objects	Y N
25. There is a history of lazy eye or vision problems in family	Y N

Hearing

Directions: Circle Y or N

Has your child had ear infections? _____	Y N
If so, how many times per year?	
What was the treatment? _____	
Has your child had a hearing evaluation?	Y N
If so, when? _____ By whom? _____	
Results _____	

Directions: Circle Y or N

1. Seems to speak as well as other children the same age	Y N
2. There is a history of hearing problems in the family	Y N
3. Seems to have difficulty hearing	Y N
4. Turns up the television louder than other members of the family	Y N
5. Seems to favor one ear over the other	Y N
6. Makes you talk loudly or repeat frequently	Y N

Recruitment and Enrollment Record

Parents as Teachers™

Please note that some of the information on this form may be gathered through the family-centered assessment process and recorded here when the assessment is complete.

Family name (type information here and tab to the next field) _____

Initial contact log

First contact with program

Date _____ Initiated by: ☐ Family ☐ PAT staff person Referral source (name) _____

How?: ☐ Phone ☐ Text ☐ E-mail ☐ In person Other:

Additional contacts before first visit

Date _____ Initiated by: ☐ Family ☐ PAT staff person Referral source (name) _____

How?: ☐ Phone ☐ Text ☐ E-mail ☐ In person Other:

Date _____ Initiated by: ☐ Family ☐ PAT staff person Referral source (name) _____

How?: ☐ Phone ☐ Text ☐ E-mail ☐ In person Other:

Notes:

Enrollment date _____

Date family assigned to parent educator _____

Family information

Address _____

Home telephone _____ Cell phone _____

E-mail _____ Best time to contact family _____

Alternate contact(s) _____ Preferred method of contact _____

Referral source(s) as applicable _____

What is the family's reason for joining the program?

-	Mother	Father	Guardian
First name			
Last name			
Marital status			
Last grade completed in school			
Language most often used			
Currently employed	☐ Yes ☐ No ☐ Full ☐ Part ☐ Seasonal	☐ Yes ☐ No ☐ Full ☐ Part ☐ Seasonal	☐ Yes ☐ No ☐ Full ☐ Part ☐ Seasonal

Additional family characteristics are recorded at the end of this form (may be gathered through the assessment process).

Siblings	Name	Gender	Age	Birth date	Living in home ☐ Yes ☐ No
					Living in home ☐ Yes ☐ No
					Living in home ☐ Yes ☐ No
					Living in home ☐ Yes ☐ No
					Living in home ☐ Yes ☐ No
					Living in home ☐ Yes ☐ No

Residents in the home other than immediate family	Name	Gender	Notes

Child information

Childs full name: _____ Date of birth: _____

Due date: _____ Birth weight: _____

Any illnesses or complications during pregnancy or delivery?: ☐ Yes ☐ No If yes, describe:

Any hospitalizations since birth? ☐ Yes ☐ No If yes, list reason:

Any current medical conditions? ☐ Yes ☐ No If yes, describe:

Name of child's healthcare provider _____ Date of last physical exam _____

Additional comments or information that parent feels would be helpful in visiting with the family:

CLIMAX SPRINGS SCREENING REPORT

NAME:	DATE OF BIRTH:
PARENTS/GUARDIANS	ADDRESS

During the Screening held on March 29th and 30th, information was obtained in the following areas: hearing, vision, health, social development, gross and fine motor and academic readiness. We wish to than you for allowing us to work with your child. If there are any concerns in the areas listed above, we will be in personal contact with you. If you have any questions about any of the information provided below, please call us and we will be happy to discuss it with you.

Hearing, Vision, and Health

Social Development

Gross Motor

Activity	**Pass(P), Beginning to Exhibit (B) Did Not Exhibit (D)**
Balance on one foot	
Right	
Left	
Walk on line	
Walk on line (heel – toe)	
Gallop	
Skip	
Catch a Ball (using hands only)	

The form completed by you on the day of screening indicated that scored in the area of gross motor development.

Fine Motor

Activity	Pass(P), Beginning to Exhibit (B) Did Not Exhibit (D)
Copies a circle	
Draws a straight line	
Draws a "X"	
Draws a person	

On the person drawing , did not include:
The form completed by you on the day of screening indicated the scored in the area of fine motor development. Areas which could be improved included:

Pre-Academics

On the Bracken Basic Concept Scale-Revised, School Readiness Composite, scored at the percentile with an age equivalent of years, months.

Areas of strength included:

Areas of weakness included:

Again, thank you for giving us the opportunity to meet and work with your child. We hope to see you often in the future.

Sincerely,

Child information

Childs full name: ______________________ Date of birth: ______________________
Due date: ______________________ Birth weight: ______________________
Any illnesses or complications during pregnancy or delivery?: ☐ Yes ☐ No If yes, describe:

Any hospitalizations since birth? ☐ Yes ☐ No If yes, list reason:

Any current medical conditions? ☐ Yes ☐ No If yes, describe:

Name of child's healthcare provider ______________________ Date of last physical exam ______________________
Additional comments or information that parent feels would be helpful in visiting with the family:

Child information

Childs full name: ______________________ Date of birth: ______________________
Due date: ______________________ Birth weight: ______________________
Any illnesses or complications during pregnancy or delivery?: ☐ Yes ☐ No If yes, describe:

Any hospitalizations since birth? ☐ Yes ☐ No If yes, list reason:

Any current medical conditions? ☐ Yes ☐ No If yes, describe:

Name of child's healthcare provider ______________________ Date of last physical exam ______________________
Additional comments or information that parent feels would be helpful in visiting with the family:

Child information

Childs full name: ______________________ Date of birth: ______________________
Due date: ______________________ Birth weight: ______________________
Any illnesses or complications during pregnancy or delivery?: ☐ Yes ☐ No If yes, describe:

Any hospitalizations since birth? ☐ Yes ☐ No If yes, list reason:

Any current medical conditions? ☐ Yes ☐ No If yes, describe:

Name of child's healthcare provider ______________________ Date of last physical exam ______________________
Additional comments or information that parent feels would be helpful in visiting with the family:

GROSS MOTOR CHECKLIST

	PASS	FAIL	COMMENTS:
Balance on one foot (hands on hips)			# of seconds
Right Foot			
Left Foot			
Walk on line – 6 feet			
Walk on line heel-toe-6 feet			
Gallop			
Skip			
Catch a ball – (toss 8" ball to chest from 6 ft.)			
No catches			
Use hands only			
Uses arms, hands and body			