Health Questionnaire

Child's Name

Birth Date

Age

Sex

Parent/Guardian

Address

(street or P.O. Box)

(city)(zip)

Phone No.

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.

<table>
<thead>
<tr>
<th></th>
<th>DTaP (DPT)</th>
<th>PCV</th>
<th>Influenza</th>
<th>Hib</th>
<th>IPV (Polio)</th>
<th>HepB</th>
<th>MMR</th>
<th>Varicella (Chicken Pox)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOSE 1</td>
<td></td>
<td></td>
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<tr>
<td>DOSE 2</td>
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</tr>
<tr>
<td>DOSE 3</td>
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<td></td>
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<td></td>
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<tr>
<td>DOSE 4</td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>DOSE 5</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

KEY:

DTaP—Diphtheria, Tetanus, & Pertussis vaccines

PCV—Pneumococcal conjugate vaccine

Influenza

Hib—Haemophilus influenzae type b vaccine

IPV—Inactivated Poliovirus

HepB—Hepatitis 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?

If yes, please describe.

Is brushing teeth a part of your child's daily routine?
## 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 styes (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?

If so, how many times per year?

What was the treatment?

Has your child had a hearing evaluation?

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
<table>
<thead>
<tr>
<th>Family Information</th>
<th>Date Family Enrolled to Parent Educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Name</td>
<td></td>
</tr>
<tr>
<td>Parent's Name</td>
<td></td>
</tr>
<tr>
<td>Contact Information</td>
<td></td>
</tr>
<tr>
<td>Parent's Address</td>
<td></td>
</tr>
<tr>
<td>Parent's Phone</td>
<td></td>
</tr>
<tr>
<td>Parent's Email</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recruitment and Enrollment Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name (type information here and label to the next field)</td>
</tr>
</tbody>
</table>

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

**Date of last physical exam:**

**Name of child's healthcare provider:**

**Any current medical conditions?**
- Yes □ No □
- If yes, describe:

**Any hospitalizations since birth?**
- Yes □ No □
- If yes, list reason:

**Any illnesses or complications during pregnancy or delivery?**
- Yes □ No □
- If yes, describe:

<table>
<thead>
<tr>
<th>Child Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
</tr>
</tbody>
</table>

**Child Full name:**

---

**Family Information:**

**Name:**

<table>
<thead>
<tr>
<th>Resides in the home other than immediate family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes</td>
</tr>
</tbody>
</table>

**siblings:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Birth date</th>
</tr>
</thead>
</table>

**Current employment:**

<table>
<thead>
<tr>
<th>Language most often used</th>
<th>Last grade completed in school</th>
<th>Marital Status</th>
<th>First name</th>
<th>Last name</th>
</tr>
</thead>
</table>

**Guardian:**

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
</table>

**Parents as Teachers:**

Form - Model Implementation Guide | 4/7/6
CLIMAX SPRINGS SCREENING REPORT

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE OF BIRTH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENTS/GUARDIANS</td>
<td>ADDRESS</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Pass(P), Beginning to Exhibit (B)</th>
<th>Did Not Exhibit (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance on one foot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk on line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk on line (heel – toe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catch a Ball (using hands only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Pass(P), Beginning to Exhibit (B) Did Not Exhibit (D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copies a circle</td>
<td></td>
</tr>
<tr>
<td>Draws a straight line</td>
<td></td>
</tr>
<tr>
<td>Draws a “X”</td>
<td></td>
</tr>
<tr>
<td>Draws a person</td>
<td></td>
</tr>
</tbody>
</table>

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,
## GROSS MOTOR CHECKLIST

<table>
<thead>
<tr>
<th>Activity</th>
<th>PASS</th>
<th>FAIL</th>
<th>COMMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance on one foot (hands on hips)</td>
<td></td>
<td></td>
<td># of seconds</td>
</tr>
<tr>
<td>Right Foot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Foot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk on line – 6 feet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk on line heel-toe-6 feet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catch a ball – (toss 8” ball to chest from 6 ft.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No catches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use hands only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses arms, hands and body</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>