

5 years

Does the child have any medical problems?

yes no If yes, please

list _____

Has the child had any surgeries? yes

no If yes, please list type

Is there a family history of illness or disease? Immediate family only. yes

no If yes, please list

Who lives in the home with the child?

Does anyone in the home smoke? yes

no

Is the child taking any medications on a daily basis? yes no If yes, please list all

medications _____

Is the child allergic to any medication?

yes no If so, what?

Please list birth history:

Hospital _____

Delivery type: vaginal C-section

Full- term? yes no How many weeks were you when child was born? _____

Birth weight? _____

Inches? _____

Did child pass hearing screen? yes no

Did child receive Hep B vaccine? yes no

Any problems at delivery? yes no If yes, please

list _____

Excessive sun exposure? yes no

Does child use a car seat? yes no

Is the home child proofed? yes no

Fire extinguishers? yes no

Smoke detectors? yes no

Any guns in the home? yes no

Any pets in the home? yes no If yes, what kind?

Any concerns with hearing? yes no

Any concerns with vision? yes no

Any problems since last visit? yes no

ER visits? yes no

5 years

Please check all the boxes that apply

Diet:

Soda/Sugar beverages/juice:

- Less than 1 glass a day
- 2 or more glasses a day

Food Reactions:

- yes no

Dairy Source:

- whole milk
- 2% milk
- 1% milk
- Other: _____

Daily Amount:

- Less than 3 servings a day
- More than 3 servings a day

Teeth:

- Good Fair Poor

Has the child seen a dentist in the last 6 months? yes no

Does the child have problems sleeping?

- yes no

Does the child have any problems wetting the bed or their pants?

- yes no

Does the child have any problems using the restroom?

- yes no

Diet:

- All 4 food groups
- Not all 4 food groups
- Picky eater
- Good appetite

Elimination:

- regular
- irregular
- soft BM
- Hard BM
- Constipation
- Diarrhea

Toilet training:

- Done
- Daytime only
- in process
- refusing
- withholding
- not toilet trained yet

Sleep/Position:

- no problems
- has problems
- sleeps through the night
- wakes once
- wakes twice
- wakes >3 times

Caregiver Relationships:

- good with mother
- poor with mother
- mother not involved
- good with father
- poor with father
- father not involved
- currently in foster care
- good with caretaker
- poor with caretaker

Relationship with siblings:

- good
- fair
- poor
- only child

Activities:

- Daycare
- preschool
- reads
- does not read

TV/Computer/Video:

- more than 2 hours a day
- less than 2 hours a day
- has a computer at home
- has video games at home
- content monitored
- content not monitored

Friends:

- yes
- no
- many friends
- few friends
- no friends

Gross Motor Assessment:

- balances 4-5 seconds
- heel to toe walk
- hops
- catches bounced ball

Fine Motor Assessment:

- copies circle
- copies square
- draws a person with 6 parts
- brushes teeth with no help
- dresses self with no help

Communication:

- fluent sentences
- counts 5 blocks
- names 4 colors
- knows 3 adjectives
- knows 4 actions
- knows what things are made of
- knows 2-3 opposites (hot/cold, up/down)

Social:

- prepares cereal
- plays games with rules
- toilets alone
- dresses self
- plays in a group
- separates easily