3 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

3 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 on each foot for 1 second
☐ broad jump
☐ pedals tricycle
☐ jumps well

Fine Motor Assessment:

☐ makes a vertical line
☐ stacks 8 objects
☐ washes hands
☐ puts on a shirt
☐ copies circle
☐ copies square

Communication:

☐ speech clear
☐ able to name 4 pictures
☐ knows 2 adjectives
☐ knows 2 actions
☐ understands 2 of 3 (cold-tired- hungry)
Recognizes 3-4 colors

Social:

☐ names friends
☐ plays interactive games
☐ separates easily
☐ able to dress self