# The Improvement Association

## CHILD HEALTH HISTORY

Childs Name:_____ Gender:_____ Birth Date:_____

1. FAMILY HISTORY

- Household Information (please complete for family and household members)

| | BIRTH DATE | LIVES WITH CHILD | | HEALTH PROBLEMS |
|---|---|---|---|---|
| | | YES | NO | |
| Father: | | | | |
| Mother: | | | | |
| **Brother and Sisters (Oldest First)** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Other (Specify Relationship)** | | | | |
| | | | | |
| | | | | |
| | | | | |

2. PREGNANCY/BIRTH HISTORY

| | YES | NO | EXPLAIN YES ANSWERS |
|---|---|---|---|
| Did mother have any health problems during this pregnancy or during delivery? | | | |
| Did mother visit physician fewer than two times during pregnancy? | | | |
| Was child born outside of a hospital? | | | |
| Was child born more than 3 weeks early or late? | | | |
| What was child's birth weight? _____lbs. _____ozs. | | | |
| Did your child have any difficulties at birth? | | | |
| Did your child have any difficulties in the nursery? | | | |
| Did child or mother stay in hospital for medical reasons longer than usual? | | | |
| Is mother pregnant now? | | | If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements) |

3. HOSPITALIZATIONS AND ILLNESSES

| | YES | NO | EXPLAIN YES ANSWERS |
|---|---|---|---|
| Has child ever been hospitalized or operated on? | | | |
| Has child ever had a serious accident (broken bones, head injuries, burns, poisoning)? | | | |
| Has child ever had a serious illness? | | | |

4. HEALTH PROBLEMS

| | YES | NO | EXPLAIN (USE ADDITIONAL SHEETS IF NEEDED) |
|---|---|---|---|
| Does child have frequent: ___ Sore Throat ___ Cough ___Urinary Tract Infections or trouble urinating ___Stomach pain, vomiting, diarrhea? | | | |
| Does child have difficulty seeing? (Squint, cross eyes, look closely at books)? | | | |
| Is child wearing (or suppose to wear) glasses? | | | **If yes, was last check up more than one year ago?** |
| Does your child have problems with ears/hearing? (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)? | | | |
| Have you ever noticed your child scratching his/her behind (rear end, anus, butt) while asleep? | | | |
| Has child ever had a convulsion or seizure? Is child taking medication for seizures? | | | **If yes ask: when did it last happen?___**<br>**What medicine?_____** |
| Is child taking any other medication now? (Special consent form must be signed for Head Start to administer any medication) | | | **What medicine?_____**<br>**(If yes, will it need to be given while child is at Head Start?____ How Often?____** |
| If you answered yes to any of the above questions, does it interfere with the child's everyday activities?<br><br>Did a doctor or other health professional tell you the child has this problem? | | | **Describe how:**<br><br>**When?** |

5. **PHYSICAL, PSYCHOLOGICAL AND SOCIAL DEVELOPMENT**
These questions will help understand your child better and know what is usual for him/her and what might not be usual that we should be concerned about.

- Can you tell me one or two things your child is interested in or does especially well?

- Does your child take a nap? ____YES ____NO if yes, describe when and how long.

- Does your child sleep less than eight hours a day or have trouble sleeping? (such as begin fretful, having nightmares, wanting to stay up late) ____ YES ____ NO If yes, describe arrangements (own room, own bed and so forth)

- How does your child tell you that he/she has to use the bathroom?

- Does your child need help in going to the bathroom? Does your child wet his/her pants?
____YES ____NO if yes, please described:

- How does your child act with adults that he/she doesn't know?

- How does your child act with children his/her own age?

- How does your child interact with older children?

- Does your child worry a lot, or is he/she afraid of anything? ___YES ___NO if yes, what things seem to cause him/her to worry or to be afraid?

- Children learn to do things at different ages. We need to know what each child already can do or is learning to do easily, and where they might need help so we can fit our program to each child. Below is a list of things children learn to do at different ages and ask when your child started to do them. Answer the best you can remember (Interview: read question or each item listed below and check off the parents answer in appropriate space.)

| | EARLIER | AVERAGE | LATER | AGE |
|---|---|---|---|---|
| Sit up without help | | | | |
| Crawl | | | | |
| Walk | | | | |
| Talk | | | | |
| Feed Self | | | | |
| Dress Self | | | | |
| Learn to use the toilet | | | | |
| Respond to directions | | | | |
| Play with toys | | | | |
| Use crayons | | | | |
| Understand what is said to him/her | | | | |

- Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? ___ YES ___NO if yes, please describe.

- Children sometimes get cranky or cry when they are tired, hungry, sick and so forth. Does your child often get cranky or cry at other times, when you can't figure out why? ___YES ___NO If yes, can you explain that

  When this happens, what do you do about it to help the child feel better?

- Have there been any big changes in your child's life in the last six months? ___ YES ___ NO If yes, please describe.

- Are you or your family having any problems now that might affect your child? ___ YES ___ NO If yes, please describe.

- Is there anything else you would like us to know about your child? ___ YES ___ NO If yes, please describe.

I have responded to the child health history to the best of my knowledge _____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

# The Improvement Association – Head Start
# Nutrition Intake Form

**Date:** _____ **Head Start Center:** _____

**Child's Name:** _____ **Birthdate:** _____

| | | | | |
|---|---|---|---|---|
| 1. How would you describe your child's appetite? | Good | | Fair | Poor |
| 2. How many days a week does your family eat meals together? | 1-2 | 3-4 | 5-6 | Everyday |
| 3. How many meals does your child eat per day? | 1 | 2 | 3 | 4+ |
| 4. How many snacks does your child eat per day? | 1 | 2 | 3 | 4+ |
| 5. How much juice does your child drink per day? | None | 1-3oz | 4-6oz | 7oz+ |

6. How much sweetened beverage (fruit punch/soda) does your child drink per day? None 1-3oz 4-6oz 7oz+

7. Does your child have any Food Allergies? Please list: _____

Which of these foods did your child eat or drink in the past week? (Below please check all that apply)

## GRAINS

- ○ **Bagels** ○ **Bread** ○ **Cereal/Grits**
- ○ **Crackers** ○ **Muffins** ○ **Noodles/Pasta /Rice**
- ○ **Rolls** ○ **Tortillas**
- ○ **Other:**_____

## MILK & OTHER DAIRY PRODUCTS

- ○ **Fat Free (skim) Milk** ○ **Low Fat (1%) Milk**
- ○ **Flavored Milk** ○ **2% Milk**
- ○ **Whole Milk** ○ **Cheese**
- ○ **Yogurt** ○ **Soy Milk**
- ○ **Other:**_____

## VEGETABLES

- ○ **Broccoli** ○ **Carrots** ○ **Corn**
- ○ **Greens** ○ **Salad** ○ **Green beans**
- ○ **Peas** ○ **Potatoes** ○ **Tomatoes**
- ○ **Other:**_____

## MEATS & MEAT ALTERNATIVES

- ○ **Chicken** ○ **Eggs** ○ **Beef/Hamburger**
- ○ **Cold Cuts** ○ **Fish** ○ **Dried Beans**
- ○ **Pork** ○ **Tofu** ○ **Peanut Butter/Nuts**
- ○ **Other:**_____

## FRUITS

- ○ **Apple / Juice** ○ **Bananas** ○ **Oranges/Juice**
- ○ **Peaches** ○ **Melon** ○ **Grapes/ Juice**
- ○ **Pears** ○ **Strawberries**
- ○ **Other:**_____

## FATS & SWEETS

- ○ **Candy** ○ **Cookies** ○ **Cake/Cupcakes**
- ○ **Donuts** ○ **Pie** ○ **Chips**
- ○ **Bacon** ○ **Sausage** ○
- ○ **Other:**_____

**Any other Questions/Concerns/ Needs from the Nutritionist**

_____

_____

_____

**Please Place in Child's Chart**
**Nutritionist to Review**

**THE IMPROVEMENT ASSOCIATION**

**DENTAL SURVEY**

**Students Name:**_____

Does your child:

| | | | |
|---|---|---|---|
| 1. Wake up during the night complaining of pain? | Yes | Sometimes | No |
| 2. Complain of sensitivity to hot and cold foods? | Yes | Sometimes | No |
| 3. Have any noticeable dental cavities? | Yes | Sometimes | No |
| 4. Have any white spots on teeth? | Yes | Sometimes | No |
| 5. Eat a lot of sweet, sticky foods? | Yes | Sometimes | No |
| 6. Eat a lot of foods containing sugar? | Yes | Sometimes | No |
| 7. Experience difficulty in biting or chewing certain foods? | Yes | Sometimes | No |
| 8. Eat a healthy and well-balanced diet? | Yes | Sometimes | No |
| 9. Brush teeth after each meal? | Yes | Sometimes | No |
| 10. Show signs of inflammation and/or bleeding gums? | Yes | Sometimes | No |
| 11. Use fluoride toothpaste? | Yes | Sometimes | No |
| 12. Have any teeth that are loose? | Yes | No | |

_____ _____

Parent/Guardian Signature Date

**THE IMPROVEMENT ASSOCIATION**

**EMOTIONAL AND BEHAVIOR PATTERN SURVEY**

**Students Name:_____**

Please circle the correct response.

Does your child:

| | | | |
|---|---|---|---|
| 1. Strikes out in anger at you or others? | Often | Sometimes | Never |
| 2. Demonstrates destructive behaviors to self and/or others? | Often | Sometimes | Never |
| 3. Ignores verbal commands? | Often | Sometimes | Never |
| 4. Talks back in an aggressive manner? | Often | Sometimes | Never |
| 5. Appears to be withdrawn? | Often | Sometimes | Never |
| 6. Displays poor peer relationships? | Often | Sometimes | Never |
| 7. Displays inappropriate responses to situations? (Laughs when crying is appropriate) | Often | Sometimes | Never |
| 8. Displays persistent sadness, boredom, low energy and poor concentration? | Often | Sometimes | Never |
| 9. Becomes influenced by others easily? | Often | Sometimes | Never |
| 10. Appears defensive and easily frustrated? | Often | Sometimes | Never |
| 11. No longer enjoys or looks forward to favorite activities | Often | Sometimes | Never |
| 12. Wanders off while in public places and/or gatherings? (Examples: Stores, parks, etc.) | Often | Sometimes | Never |
| 13. Does your child need individual attention frequently? | Often | Sometimes | Never |

_____ _____

Parent/Guardian Signature Date