

Developmental Health History

Child's Name/Nickname _____

Date of Birth _____

Physical Health

1) List any past health problems your child has had: _____

2) List any current health problems: _____

3) Does your child have any allergies? (If so, to what?) _____

4) Does your child take any medications regularly? (If so, what?) _____

5) Has your child been hospitalized recently? (If so, for what?) _____

6) Does your child have any reoccurring health problems such as: asthma _____ diabetes _____ seizures _____
earaches _____ hemophilia _____ other _____

7) Does your child have any problems with any of the following? Speech _____ walking _____
running _____ seeing _____ hearing _____ using their hands _____ (such as with puzzles or small items?)

Please explain any marked above on item seven: _____

Daily Living

1) Does your child have any food allergies? _____

2) Does your child like to sleep with a favorite item, such as a stuffed animal, blanket, etc.? _____

3) Does your child need help when changing clothes? _____

4) Is your child accustomed to resting after lunch? If so, for what length of time? _____

Social Relationships

1) Is your child accustomed to playing alone or with other children? _____

2) Does your child have a favorite toy? _____

3) Describe your child's play with others: Aggressive _____ Shy _____ Withdrawn _____

4) Is your child frightened by any of the following: Animals _____ Loud noises _____ the dark _____

Storms _____ Anything else _____

5) Who does most of the discipling at home? _____

Is there any other information you wish to share that would assist us in helping you to train your child? _____

Parent/Guardian signature _____

Date _____