INITIAL HEALTH ASSESSMENT

IDENTIFYING INFORMATION:

LEGAL NAME OF CHILD: ____

BIRTHDATE: ___________________ AGE: _________ SEX: _________ GRADE: _________________

ADDRESS: ____

This form is completed by: ______________________________ Relationship to Child: ________________________

MOC PHONE: Home _____________________ Work ____________________ Cell ____________________

FOC PHONE: Home _____________________ Work ____________________ Cell ____________________

Message Number: ______________________ Best time to call: ________________________

Child lives with: Both Parents ____ Mother ____ Father ____ Other (explain) ____________________________

Language spoken in home: English: ____ Spanish ____ Other (list) _____________________________________

My child has the following health care coverage: Medicaid: ____ CHP+ _____ Private:_____ None: _____

PREGNANCY AND BIRTH:

Month into pregnancy that medical care began: ______________ Length of pregnancy: ____________

Were there any medications taken while pregnant?

Explain: ____

Length of labor: ________________ Birth Weight: ________________

Did baby come home with mother? Yes ____ No ____

Explain: ____

Did the baby need oxygen after birth: Yes ____ No ____

Explain: ____

Did baby turn yellow enough to be treated? Yes ____ No ____

Explain: ____

DEVELOPMENTAL HISTORY:

Did your child crawl by 9 months? Yes ____ No ____

Did your child walk by 18 months? Yes ____ No ____

Did your child say words by 15 months? Yes ____ No ____

Was your child toilet trained by 3½ years? Yes ____ No ____

Were there problems with balance coordination? Yes ____ No ___

Were there problems with fine motor skills? (buttons, handwriting, picking something up) Yes ____ No ____

Do you have other concerns about your child's development? Yes ____ No ____

Explain: ____

ILLNESSES, HOSPITIALIZATIONS, SURGERIES, AND/OR ACCIDENTS:

Major Illnesses: ____

Hospitalization/Surgeries: ____

Accidents/Injuries: ____

Child's Doctor: ___________________________ Date of Last Visit: _________ Reason: _________________

BODY SYSTEMS HISTORY:

TEETH:

Are there any dental concerns? Yes ____ No ____

Explain: ____

Date of Last Dental Exam: ________________ Dentist: _____________________________

EARS:

Does your child have any known hearing problems? Yes ____ No ____

Explain: ____

Do you have any concerns about your child's hearing? Yes ____ No ____

Explain: ____

Ear Infections? No ___ Yes ___ Age when started? _____ How many per year? _____

Within last year? No ___ Yes ___ Were PE tubes placed? No ___ Yes ___ Number of sets? _____

EYES:

Does your child have any problems seeing? Yes ____ No ____

Explain: ____

Does your child wear glasses/contacts? Yes ____ No ____

When? ____

Date of last eye exam? _________________ Doctor's Name: _____________________________

CARDIAC:

Does your child have any heart problems? Yes ____ No ____

Explain: ____

Does your child fatigue easily, or have poor endurance? Yes ____ No ____

Explain: ____

RESPIRATORY:

Does your child have any breathing problems? Yes ____ No ____

Explain: ____

Is he/she prone to upper respiratory infections? Yes ____ No ____

Explain: ____

Does your child have asthma? Yes ____ No ____

Triggers: ____

Uses inhaler, nebulizer, or medication? Yes ____ No ____

GASTROINTESTINAL AND URINARY:

Does your child have any problems going to the bathroom? Yes ____ No ____

Explain: ____

Bedwetting: Yes ____ No ____

Constipation: Yes ____ No ____

Difficult to train: Yes ____ No ____

Does your child have dietary/food needs or concerns? Yes ____ No ____

Explain: ____

Does your child have frequent stomach aches? Yes ____ No ____

Explain: ____

SKELETAL AND MUSCULAR:

Has your child ever had a broken bone? Yes ____ No ____

When and which one? ____

Does your child have any physical disabilities? Yes ____ No ____

Explain: ____

Are there any restrictions for activity? Yes ____ No ____

Explain: ____

NEUROLOGICAL:

Has your child ever had seizures? Yes __ No __ Date of last seizure:_____________

Does your child have frequent headaches? Yes __ No __ Explain: ______________________

Has your child ever had a head injury or concussion? Yes __ No __ If unconscious, how long? ________

After injury: Dizziness?___ Memory problems? ___ Headaches?___ Fatigue?___

Was a physician seen? Yes __ No __ Who? _________________________

Hospitalized? Yes__ No__ Where? ________________________

Does your child have sleeping/bedtime concerns? Yes __ No __

Explain: ____

Does your child have a limited attention span? Yes __ No __

Do you think your student is distractible? Yes __ No __

Is your student impulsive? Yes __ No __

ALLERGIES: (Identify and explain)

Medications allergies? Yes __ No __ What/Reactions: __________________

Food Allergies? Yes __ No __ What/Reactions: __________________

Insect/wasp/bee sting allergy? Yes __ No __ What/Reactions: __________________

Environmental Allergies? Yes __ No __ What/Reactions: __________________

Seeing an Allergist? Yes __ No __ Who/When?: ______________________

MEDICATIONS:

Is your child currently taking medications (prescription and/or over-the-counter)? Yes ____ No ____

List Name, Dose, and Time: ____

____

____ __________________

Signature of person completing this form Date

Interpreter (if applicable): ____