ROOTS and FRUITS
DEVELOPMENTAL HEALTH HISTORY

Child's Name**:** _____ Nickname: _____

Birthdate: _____ /_____/_____

PHYSICAL HEALTH

Check Illnesses child has had or has:

Asthma	☐	Epilepsy	☐	Pneumonia	☐	Strep Throat	☐
Chicken Pox	☐	Measles	☐	Rheumatism	☐	Whooping Cough	☐
Diabetes	☐	Mumps	☐	Scarlet Fever	☐	Other _____	

Allergies (food, drug, bee sting, animals, etc.) list type, symptoms, and treatment required:

_____
_____
_____

Immunization (Date of most recent shot).

Small Pox _____ (month/year) Rubella_____ (month/year) Polio _____ (month/year)
Mumps _____ (month/year) Diphtheria _____ (month/year) Measles _____ (month/year)
Tetanus _____ (month/year) Tuberculosis _____ (month/year) Other_____

Copy of immunization record attached and signed by doctor: ☐ Yes ☐ No

Date and clinic of last medical exam _____

Does your child have any special needs that require accommodation by the provider? If so, please list:

_____
_____
_____

Does your child have a condition that, according to current medical information, would pose a direct threat to the health or safety of others in the program? ☐ Yes ☐ No

Do you have any other concerns about your child's physical health?

_____
_____
_____

DEVELOPMENT (compared to other children this age)

Age Child began talking _____ Does your Child speak in words _____ or sentences_____. Does your child have any challenges with talking or making sounds? Please explain _____
Does your child speak other languages? _____

Age Child Began: Sitting _____ Crawling _____ Walking _____ Is your child a good climber? _____ Does your child fall easily? _____

Does your child have any challenges with walking, running, or moving? Please explain

_____

Does your child have any challenges seeing? Please explain

_____

_____

Does your child have any challenges hearing? Please explain

_____

_____

Does your child have any challenges using her or his hands (such as with puzzles, drawing, small building pieces)? Please explain

_____

_____

Does your child have any challenges with mood or behavior? Please explain.

_____

_____

Describe your child's large motor skills:_____Any concerns? _____

Describe your child's fine motor skills (such as with puzzles, drawing, small building pieces)_____Any concerns? _____

Describe your child's temperament_____Any concerns regarding behavior? _____

DAILY LIVING

Eating

What is your child's typical eating pattern? _____

_____

What foods does your child like? _____

Dislike? _____

How well does your child use table utensils (cup, fork, spoon)? _____

Are there any special foods or eating instructions?

_____

_____

Toileting

How does your child indicate bathroom needs? _____

Word (s) for *urination*: _____ Word (s) for bowel *movemen*t: _____

Special words for body parts: _____

What are your child's regular bladder and bowel patterns?

_____

_____

Do you want us to follow a particular plan for toileting? _____

For toddlers, please describe use of diapers or toileting equipment (such as potty, toilet seat adapter). _____

Sleeping and Dress

What are your child's regular sleeping patterns? _____

Awakes at: _____ Naps at: _____ Goes to bed at: _____

What help does your child need to get dressed? _____

SOCIAL RELATIONSHIPS/PLAY

What ages are your child's most frequent playmates? _____

How does your child normally respond to other children? (Circle all that apply) Shy? Friendly? Withdrawn? Assertive? Additional thoughts:

_____

Does your child need extra time/preparation to change from one activity to another? _____

Does your child play well alone? _____ What is your child's favorite activity/toy?

_____

Is your child frightened by (circle all that apply) Animals? Rough children? Loud noises? New experiences? The dark? Storms? Anything else? _____

What is your approach to behavior guidance? _____

Do both parents approach behavior guidance in the same manner?_____

_____

With which adults does your child have frequent contact? _____

How does your child relate to strangers? _____

What makes the child frustrated or upset? _____

How do you comfort your child? _____

Does your child use a special comforting item (such as a blanket, stuffed animal, doll)?_____

_____

Has your child ever experienced any physical, emotional, or mental trauma? i.e. Divorce, Sexual Abuse, Witness to Violence, etc.

_____

_____

If yes, has the child undergone any kind of evaluation or treatment?

_____

_____

Briefly describe what you sense your child's gifts or talents are: (i.e. Is she/he really drawn to music, art/drawing, drama, dancing, singing, nature, books, numbers, spiritual curiosity?)

_____

_____

_____

_____

_____

CULTURAL BACKGROUND

Describe child's ethnicity: _____

What are your family's most important cultural values? (e.g. respect, responsibility, interdependence, family, etc…)

_____

_____

_____

_____

_____

_____

What gives you and your children a sense of belonging (e.g., religion, occupation, history)?

What are your family's religious/spiritual beliefs, if any?

What is the primary language of parent (s)? _____

What are important cultural customs/holidays you honor within your home?

What emotions are valued within your home? _____

What are the important features of family? e.g. sharing meals together

What are important family rules that our program should be aware of?

Any additional information you would like to share with us?

Parent (s)
Signature:_____
_____

Date: _____