CHICO UNIFIED SCHOOL DISTRICT
1163 E. SEVENTH ST., CHICO, CA 95928

SCHOOL:		PHONE:		FAX:	

Initial Health, Developmental, and Social History

Child's Name ______________________________ Birth date ____________________

History given by ____________________ Relationship to child ____________ Date ____________

Address ______________________ City ______________ Zip code ______________

Phone: Home (_____) ____________ Work (_____) ____________ Cell (_____) ______________

Best Phone # to use: (_____) __________________ Best time to call: ______________________

Primary Language at home ____________________ Grade ________

Family History:

	Full Name	Age	Education	Occupation
Mother				
Father				
Legal Guardian				

Child lives with: ☐Mother ☐Father ☐Joint custody Ethnicity: ______________________________

Other adults (specify) ______________, ______________, ______________, ______________

Other Children in the home: (in order of age)

Name	Birth date	Relationship	Grade	School difficulties

Has anyone in your family had any of the following problems (check all that apply)

	Child's mother	Child's father	Child's brother(s) (number)	Child's sister(s) (number)	Others (specify)
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Speech problems					

Who cares for the child on a daily basis: ______________________________ ______________________
Name Relationship

Family lives in: ☐Single family dwelling ☐Apartment ☐Motel ☐Other (specify): ______________

Current Medical:

Do you have Health Insurance? ☐Private ☐Healthy Families ☐MediCal ☐CalOptima ☐None

Dental insurance? ☐Yes ☐No Vision Insurance? ☐Yes ☐No

Name of medical provider: ______________________________ City: __________________ Phone: _____________

Date of last: Doctor's visit: _________________ Dental exam: _________________ Eye exam: __________________

Diagnosed medical conditions? ☐Yes ☐No Explain:

____

Medication taken regularly? ☐Yes ☐No List name of Medication and Reason for taking:

____

____

Allergies: (Food, meds, environment, other): ☐ None known ☐Yes Explain: _________________________________

Allergy is life threatening? ☐Yes ☐No EpiPen needed ☐Yes ☐No Antihistamine needed: ☐Yes ☐No

Has your child ever been examined by a specialist? ☐Yes ☐No Specialist/Specialty: _________________________

Specialist/Specialty: ______________________________ Specialist/Specialty: ______________________________

Has your child had any problems with: (please explain)

Problem	Current	Past	Explain:
Life Threatening Allergies			____________________
Asthma			____________________
Diabetes			____________________
Seizures			____________________
Cancer			____________________
(central line, chemo, remission, cure)			
Migraines/Headaches			____________________
Nasal Congestion			____________________
Chronic Cough (how long: ____)			____________________
Nose bleeds			____________________
Heart			____________________
Lungs			____________________
Kidneys			____________________
Stomach			____________________
Arms			____________________
Legs			____________________
Frequent Ear Infections			____________________
Hearing Loss			____________________
Emotional Stress			____________________
Fainting			____________________
Skin Disorder			____________________
Blood Disorder			____________________
Endocrine Disorder			____________________
Developmental Disability			____________________
ADD/ADHD (circle one)			____________________
Glasses/Contacts (circle one)		.	Distance Near ____________________
Operations			____________________
Hospitalizations			____________________

. **No known health conditions/problems.**

Has your child had any serious medical condition not explained above: Yes No At what age?
Explain:

____

____

Habits: Check all that apply to your child **now:**

☐Jealous ☐Nail biting ☐Tires easily ☐Extreme shyness ☐Nightmares ☐Sleep problems
☐Irritable ☐Discipline problems ☐Over active ☐Under active ☐Emotional ☐Temper tantrums
☐Inattentive ☐Short attention span ☐Speech difficulty ☐Facial tic/grimace ☐Special fears: ________________
☐Constipation ☐Bed wetting ☐Daytime wetting ☐Soils pants ☐Poor appetite ☐Eats dirt/paint
☐Walks on toes ☐Holds breath ☐Accident prone ☐Poor coordination
☐Thumb/finger sucking ☐Rocking/Head banging ☐Fights with other children

Birth History:

Full term Premature Late How early or late: ____

Vaginal Cesarean birth Complications during: Pregnancy Labor Delivery

Explain: ____

Birth weight: ________lbs. _________oz. Length: _________ inches

Immediately after birth were there problems with:

Breathing: Yes No Blueness: Yes No Yellow Jaundice: Yes No

Any special type of hospital care: Yes No Explain: ____

Did mother and baby leave hospital at the same time: Yes No If not, why: ____________________________

____

Breast fed: Yes No Until what age: ______

Bottle fed: Yes No Until what age: ______ Special Formula: ______________________

Developmental History:

During the first year were there problems with: (check all that apply):

☐Feeding problems ☐Colic ☐Allergies ☐Vomiting ☐Diarrhea ☐Poor weight gain ☐Growth problems

At what age did your child: (Answer to the best of your ability)

Roll over: _________ Crawl: ___________ Toilet trained: ___________ day _________ night

Sit alone: _________ Walk: ____________ Began school: ___________ years

First word: ________ Sentences: _________ Understand/Follow instruction: __________

Were there any problems during any of these times? ☐Yes ☐No Explain: ___________________________

____

____

Has growth and development been similar to that of brothers and/or sisters? ☐Yes ☐No

What hand does your child use most of the time ☐Right ☐Left ☐Both

Nutrition:

How many days, out of the 7 days in a week, does your child:

Eat breakfast: ______days out of 7 Eat lunch: ______days out of 7 Eat sweets: ______days out of 7

Eat "fast food" for dinner: ________days out of 7 Eat home-cooked meals for dinner: ________days out of 7

Eat at least 1 fruit: ________days out of 7 Eat at least 1 vegetable: ________days out of 7

How many times does your child brush his/her teeth? ☐Once a day ☐Twice a day ☐Occasionally

The teeth are brushed: ☐Independently ☐With help

How often are teeth flossed? ☐Not flossed yet ☐Once a day ☐1-2 times a week ☐When food is stuck

Social History:

Where does your child sleep? (check all that apply) ☐Own room ☐Own bed ☐Shared room ☐Shared bed

Did your child attend a preschool program: ☐Yes ☐No Where? ____

Describe your child's activities/ responsibilities at home: ____

____

Describe your child's activities outside the home (teams, clubs, work, etc.) ____________________________

____

How many hours of TV does your child watch daily? _______ hours

Favorite programs? ____

How much physical activity does your child get outside of school each day? ________________ hours

What does your child do with his/her free time? ____

____

Does your child have any other children his/her own age to play with? ☐Yes ☐No

Does your child have any difficulty "getting along with" others his or her own age? ☐Yes ☐No

or trouble getting along with Adults? ☐Yes ☐No

Please explain: ____

Are there any family problems which currently might affect your child such as:

Emotional stress: ☐Yes ☐No Financial stress: ☐Yes ☐No

Parent separation: ☐Yes ☐No Death in the family: ☐Yes ☐No

Other (explain): ____

What concerns you most about your child?

____

____

____.

What pleases you most about your child?

____

____

____