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

SCHOOL:		PHONE:		FAX:	

Triennial Health, Developmental, and Social History

Child's Name _____ Birth date _____

Primary Language at home _____Grade _____

History given by _____ Relationship to child _____ Date _____

Address _____ City _____ Zip code _____

Phone: Home (_____) _____Work (_____) _____ Cell (_____) _____

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

Child lives with: ☐Mother ☐Father ☐Joint custody Child's Ethnicity: _____

Other adults (specify) _____, _____, _____, _____

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

Name	Birth date	Relationship	Grade	School difficulties

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 ☐Emergency MediCal ☐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: _____

Medical conditions diagnosed in the last year? ☐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: _____

Is allergy life threatening ☐Yes ☐No EpiPen needed ☐Yes ☐No Antihistamine needed: ☐Yes ☐No

Has your child seen a medical specialist in the last year? ☐Yes ☐No Specialist/Specialty: _____

Specialist/Specialty: _____ Specialist/Specialty: _____

In the last year has your child had any serious medical condition not explained above: ☐Yes ☐No

Please 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

Social History:

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

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

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: _____

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

What concerns you most about your child? _____

_____

_____

What pleases you most about your child? _____

_____

_____