Child and Family History & Family Assessment Tool

Dear Parent/Guardian:

Please complete the following questions as best you can. The information you provide to us about the child's health and development will be very helpful in the Early On evaluation process.

If you need help completing this form, please call (

ABOUT THE CHILD & FAMILY:

1. Child's Name: _____
   Last First Middle

Sex: ☐ Male ☐ Female Birth Date: _____ mo/day/year Age: _____

Ethnic Heritage: Hispanic/ Latino? ☐ Yes or ☐ No

Race: ☐ American Indian/Alaskan Native ☐ African American ☐ Asian American
☐ Hawaiian Native/Pacific Islander ☐ White/Middle Eastern

2. Mother's Name: _____
   Last First Middle

Birth Date: _____ mo/day/year Telephone: _____ (area code) phone number Email: _____

Address: _____
Street City State Zip

3. Father's Name: _____
   Last First Middle

Birth Date: _____ mo/day/year Telephone: _____ (area code) phone number Email: _____

Address: _____
Street City State Zip

4. The child's parent/s are: ☐ Single ☐ Married ☐ Divorced ☐ Separated
☐ Widowed ☐ Living together but not married ☐ Unknown

5. What is the primary language spoken in the child's home? _____

6. If the child lives with a guardian/foster parent, is that guardian/foster parent a relative?

☐ Yes. Relationship: _____ or ☐ No

Guardian/Foster Parent's names: _____

Address: _____

Phone Number: _____

Foster Workers Name: _____ Phone Number: _____

Foster Care Agency: _____

7. Check all the people that live in the child's home:

☐ Mother/Stepmother

☐ Father/Stepfather

☐ Guardian/s

☐ Brothers. How many? _____ Their ages: _____

☐ Sisters. How many? _____ Their ages: _____

☐ Other family members, please list: _____

☐ Friends/other people, please list: _____

☐ Animals, please list: _____

ABOUT THE PREGNANCY:

1. Did the mother have regular prenatal care? ☐ Yes ☐ No ☐ Unknown

How often: _____

Doctor's name: _____

2. How was the general health of the mother during pregnancy?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unknown

3. Were any of the following used during pregnancy?

☐ Cigarettes. If yes, how many per day? _____

☐ Alcohol. If yes, how often? _____

☐ Illegal Drugs. If yes, which ones? _____

☐ Prescription Drugs. If yes, which ones? _____

☐ None of the above.

4. Did the mother have any of the following problems or conditions during pregnancy?
   - ☐ Diabetes (sugar)
   - ☐ Emotional Stress
   - ☐ Injury or serious illness
   - ☐ Preeclampsia (high blood pressure)
   - ☐ Unexpected bleeding or spotting
   - ☐ Other, please describe: _____

   _____

5. Any additional information about the pregnancy you want to share: _____

   _____

ABOUT THE BIRTH:

1. Where was the child born?

   Name of the hospital: _____

   City and State: _____

2. How much did the child weigh and how long was the child at birth?

   Weight: _____

   Length: _____

3. The child was born:

   - ☐ On the due date of _____
   - ☐ Before the due date. By how much? _____
   - ☐ After the due date. By how much? _____

4. Was the birth: ☐ Vaginal or ☐ C-Section (surgically removed)

5. Were any of the following used during birth?
   - ☐ Pain medication (Epidural)
   - ☐ Forceps or Vacuum (tool to pull baby out)
   - ☐ None

6. Were there any problems during birth? ☐ Yes or ☐ No

   If yes, explain: _____

   _____

7. Were there any problems with the child after delivery? _____

   _____

   _____

8. How long did the child stay in the hospital? _____days, the mother? _____days

9. Where there any problems in the first few weeks at home? ☐ Yes or ☐ No

If yes, please describe: _____

10. Did the child pass the newborn hearing screening at the hospital? ☐ Yes or ☐ No

11. Any additional information about the birth: _____

_____

_____

ABOUT THE CHILD AND FAMILY'S HEALTH:

1. Was/is the child breastfed? ☐ Yes or ☐ No

2. What does the child typically eat and drink in a day?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

3. Does your child cough, gag, choke or get teary eyed when eating or drinking? ☐ Yes or ☐ No

4. How many hours does the child sleep in a 24 hour period? _____

5. Has the child ever had:

☐ Anemia (low iron)	☐ Breathing problems	☐ Chicken Pox
☐ Colic (upset stomach, crying)	☐ Ear infections	☐ Eczema
☐ Frequent fevers	☐ Heart trouble	☐ Jaundice (yellow skin)
☐ Measles	☐ Meningitis	☐ Mumps
☐ Problems urinating	☐ Reflux	☐ Rheumatic Fever
☐ Rubella	☐ Scarlet Fever	☐ Seizures
☐ Stomach/Bowel problems	☐ Whooping Cough	☐ None of the Above

☐ Other serious or chronic illness: _____

_____

6. Does the child have allergies or ever had an allergic reaction (bad effect) from any of the following?

☐ Outdoor or indoor allergies (grass, pollen, mold, animals, etc.)

If so, please list: _____

☐ Food allergies. (peanuts, milk, wheat, etc.)

If so, please list: _____

☐ Medicine or shots. (immunizations, penicillin, etc.)

If so, please list: _____

☐ Other allergies.

Please list: _____

☐ No, the child has no allergies that I know of.

7. How would you rate the general health of the child?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

8. Are the child's shots up to date? ☐ Yes ☐ No ☐ Unknown

9. Date of the first DTP? _____

10. When was the child's last physical exam by a doctor? _____

11. Where does the child receive health care?

Doctor's name: _____

Street Address: _____

City, State, ZIP: _____

Phone number: _____ FAX number: _____

12. Has the child had any accidents or injuries? ☐ Yes or ☐ No

If yes, please describe: _____

13. Has the child ever been hospitalized?

☐ Yes or ☐ No If yes, please tell us about it.

Date	How many days	Illness	Name of Hospital
_____	_____	_____	_____
_____	_____	_____	_____

14. Does the child take prescription medications?

☐ Yes or ☐ No If yes, please tell us about them.

Name of medicine	Amount	How often	For what	Name of ordering doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

15. Does the child take over the counter medications to include vitamins and herbal medicines?

☐ Yes or ☐ No If yes, please tell us about them.

Name of medicine	Amount	How often	For What
_____	_____	_____	_____
_____	_____	_____	_____

16. What medical problems do people in the child's family have?

Family Member	Medical Problem		
Mother	☐ Alcohol Abuse	☐ Anxiety (nerve problems)	☐ Cancer
	☐ Depression	☐ Diabetes (sugar)	☐ Drug Abuse
	☐ Hearing Problems	☐ Heart problems	☐ High Blood Pressure
	☐ Learning Disability	☐ Overweight	☐ Vision Problems
	☐ Other: _____		
Father	☐ Alcohol Abuse	☐ Anxiety (nerve problems)	☐ Cancer
	☐ Depression	☐ Diabetes (sugar)	☐ Drug Abuse
	☐ Hearing Problems	☐ Heart problems	☐ High Blood Pressure
	☐ Learning Disability	☐ Overweight	☐ Vision Problems
	☐ Other: _____		
Sisters	☐ Alcohol Abuse	☐ Anxiety (nerve problems)	☐ Cancer
	☐ Depression	☐ Diabetes (sugar)	☐ Drug Abuse
	☐ Hearing Problems	☐ Heart problems	☐ High Blood Pressure
	☐ Learning Disability	☐ Overweight	☐ Vision Problems
	☐ Other: _____		
Brothers	☐ Alcohol Abuse	☐ Anxiety (nerve problems)	☐ Cancer
	☐ Depression	☐ Diabetes (sugar)	☐ Drug Abuse
	☐ Hearing Problems	☐ Heart problems	☐ High Blood Pressure
	☐ Learning Disability	☐ Overweight	☐ Vision Problems
	☐ Other: _____		

ABOUT THE CHILD'S DEVELOPMENT:

1. At what age did the child do each of the following?

Smile: _____ Reach for objects: _____ Name objects: _____

Sit unsupported: _____ Crawl: _____ Walk alone: _____

2. Please check all of the following that describe the child:

☐ Social, friendly	☐ Happy
☐ Relaxed, calm	☐ Shows affection
☐ Pushy, bullies others	☐ Scared, fearful
☐ Cries easily	☐ Hard to comfort
☐ Clumsy, falls easily, uncoordinated	☐ Hyper, restless, can't sit still
☐ Nervous, worried	☐ Shy, withdrawn, keeps to self
☐ Engages in self-hurting behavior	☐ Rocks excessively
☐ Eats inedible objects	☐ Apathetic, listless, no emotions
☐ Gets angry easily	☐ Other: _____

3. Do you have concerns about the child's ability to: *Check all that apply*

☐ Get around (crawl, walk, run)	☐ Talk and listen
☐ Think, learn, play with toys	☐ Feed, eat
☐ Have fun with other children	☐ Look at you
☐ Bathe, undress, dress, go to bed	☐ Sleep
☐ Calm down, quiet down	☐ Relate in a meaningful way with other family members
☐ See or hear	

Other, please explain: _____

_____

4. Does the child have the opportunity to play with other children near their own age?
☐ Yes or ☐ No How Often? _____

5. Has the child ever attended daycare or nursery school?
☐ Yes or ☐ No Name of school/program? _____

6. Has the child ever lived away from their parents?
☐ Yes or ☐ No With whom and when? _____

Family Assessment Tool: *These questions are used to understand your family's resources, priorities, and concerns related to your child's development.*

About your day: (e.g., go to the store, give kids a bath, prepare meals, walk the dog)

What happens most mornings?

What happens most afternoons?

What happens most nights?

What happens most weekends?

Which of the above activities you mentioned are going well?

Which of the above activities you mentioned are more difficult?

Which of the above activities you mentioned does your child not like and what makes it difficult or uncomfortable for your child?

Who are the key family members, other caregivers, or important people who spend time with your child and where?

What does your child enjoy and what holds your child's interest (e.g., people, places, things)?

What makes your child happy, laugh, and/or smile?

Are there activities that you used to do before your child was born that you would like to do again?

Are there new activities that you and your child would like to try?

Anything else you would like to share about your family and/or child?

Parent/Guardian Signature _____ Date _____