HEALTH PROFILE

Child's name ____ **Birth Date** ___________________

Parent/Guardian names __________________________________ **Date Completed** ______________

HEALTH HISTORY

Age of child			
Were there any complications during the pregnancy?	Y		N
If yes, what were they?			
Were there any difficulties during labor or delivery?	Y		N
If yes, what were they?			
Did your child have any special conditions at birth? (prematurity, jaundice, medical diagnosis, etc.)	Y		N
If yes, what were they?			
Has your child had any illness with a high fever? (104 longer than 2 days)	Y		N
Has your child had a serious illness or injury?	Y		N
If yes, please explain			
Has your child been screened for vision problems?	Y	N	Result
Has your child been screened for hearing problems?	Y	N	Result
Has your child been screened for lead level?	Y	N	Result

CURRRENT HEALTH

Does your child get regular medical checkups?	Y	N
By whom?		
Have there been any concerns raised?	Y	N
If so, please explain		
Does your child have a current or chronic medical condition?	Y	N
If so, please explain		
Does your child take medication regularly?	Y	N
Why and what is it?		
Does your child have any allergies?	Y	N

If so, what are they?		
What strategies are used to protect the child from communicable illnesses?		
Is the child fully immunized?	Y	N

GENERAL DEVELOPMENT

Has your child had a Developmental Screening? (ex. ASQ or Denver Developmental)	Y	N
If so, what if any, concerns were raised?		
Is your healthcare provider ok with your child's height and weight?	Y	N
Do you or someone else have any concerns about general growth and development?	Y	N
If so, what are they?		
Do you or someone else have any concerns about your child's behavior?	Y	N
If so, what are they?		
What things can your child do very well?		
What things are challenging for your child?		

DENTAL HEALTH

Does your child see a dentist regularly?	Y	N
Does anything appear abnormal on the child's teeth or gums? (swelling, redness, apparent decay)	Y	N
Is brushing part of your child's daily routine?	Y	N
Does your child fall asleep with a bottle in his/her mouth?	Y	N

NUTRITION

Is your child on a special diet?	Y	N
If so, describe the diet.		
Does your child have any diet-related health problems? Diabetes allergies other	Y	N
If so, what are they?		

Does your child eat things not usually considered food e.g. paste, dirt paper?	Y	N
What is eaten?		
What are some of your child's favorite foods?		
What foods does your child dislike?		
How much water does your child normally drink throughout the day?		
Is your child taking a vitamin or mineral supplement?	Y	N

Please list what your child eats or drinks on a typical day.			
TIME	PLACE	FOOD	AMOUNT

SLEEP

Does your child have regular nap and bed times?	Y	N
How many hours does your child sleep per day?		
Describe any concerns you have about your child's sleep.		

SAFETY

Does your child ride in an approved car seat?	Y	N
Is a helmet used for skating or biking?	Y	N