

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

Date _____

Child's Full Name _____

Date of Birth _____ Race _____ Sex _____

Name of Parent or Guardian completing form _____

Please answer the questions on this form. We feel this information will help us to be more effective in working with your child.

Physician's Name _____ Contact Number _____

Attach shot records.

<u>Dates of required immunizations</u>		<u>Date</u>
_____	Tetanus (DTaP or Td)	_____
_____	Chicken Pox (Var)	_____
_____	Measles (MMR)	_____
_____	_____ 3 day (Rubella)	_____
_____	_____ 10 day (Rubella)	_____
_____	Hepatitis (Hep B)	_____

<u>Childhood diseases child has had</u>		
_____	Scarlet Fever	_____
_____	Rheumatic Fever	_____
_____	Mumps (MMR)	_____
_____	Strep Throat	_____

Surgery _____ Date _____

Is your child taking over-the-counter or prescribed medication regularly at home? _____ Yes _____ No
If yes, what? _____

Is your child taking vitamins regularly at home? _____ Yes _____ No
If yes, what? _____

List any known allergies to food or environment. _____

What is the allergic reaction? _____

Have you ever suspected or has your child ever had seizures? _____

Does your child dislike any foods? _____ If so, what? _____

What is your child's favorite activity at home? _____

Does your child have temper tantrums? _____ does your child bite his/her nails? _____
Twist his/her hair? _____ Does your child complain of feeling ill often? _____

Does your child have a regular playmate? _____ Same age _____ Older _____ Younger _____

Does your child get along well with groups of children or is he/she more of a loner? _____

If you could describe your child in one word, what would it be? _____
Please list your child's strong points, such as happy, curious, loving.. _____

Is there anything else, medical or otherwise that we need to know about your child?

