SHADES of Development

Health History Check List

Child's Name_____ D.O.B._____ Parent's Name_____

The information below will help SHADES of Development provide the best possible care for your child's special needs. Please include any pertinent information, not discussed in the questions below, that may assist us with your child's care. Circle the correct answer.

Pregnancy and Birth

❑Yes ❑No 1) Were there any problems with the pregnancy or birth of your child?_____
_____

❑Yes ❑No 2) Was his/her birth weight under 5 1/2 pounds?

❑Yes ❑No 3) Did your baby have any problems in the hospital? If yes explain_____
_____

Medical Information

❑Yes ❑No 4) Has your child ever been hospitalized overnight? If yes, why?_____
_____

❑Yes ❑No 5) Does your child have asthma or wheezing?

❑Yes ❑No 6) Does your child have speech or hearing problems?

❑Yes ❑No 7) Has your child had more than two ear infections in one year?

❑Yes ❑No 8) Has your child had tonsillitis?

❑Yes ❑No 9) Does your child have trouble with his/her eyes or with seeing?

❑Yes ❑No 10) Does your child have seizures, fits, or shaking spells?

❑Yes ❑No 11) Has your child had a bladder or kidney infection?

❑Yes ❑No 12) Does he/she have burning when urinating?

❑Yes ❑No 13) Have you ever been told that your child has a heart murmur?

❑Yes ❑No 14) Is your child able to play as hard as other children?

❑Yes ❑No 15) Has your child ever had a bumpy or swollen reaction to a TB test?

❑Yes ❑No 16) Has your child ever been exposed to TB?

❑Yes ❑No 17) Has your child ever had worms?

❑Yes ❑No 18) Does your child have any type of problem with his/her genital area?_____

❑Yes ❑No 19) Does your child have any bladder control problems?

❑Yes ❑No 20) Has your child ever been tested for ADD or ADHD?

❑Yes ❑No 21) Has your child ever been diagnosed with ADD or ADHD?

❑Yes ❑No 22) Is your child currently taking any type of medication? If so, what?_____

❑Yes ❑No 23) Is your child a hemophiliac, free bleeder?

❑Yes ❑No 24) Does your child have any allergies or reactions to medicine, insects, food, sunscreen etc?
If so, what?_____

❑Yes ❑No 25) Is your child on a heart monitor?

❑Yes ❑No 26) Does your child have tubes in his/her ears?

Older Girls

❑Yes ❑No 27) Has your daughter began her menstrual cycle? If yes, how old was she when she began?

❑Yes ❑No 28) Does she have any problems with her menstrual cycle?

General Development

❑Yes ❑No 29) Is your child in special education classes at school?

❑Yes ❑No 30) Does your child get along with other children?

❑Yes ❑No 31) Is your child usually happy?

❑Yes ❑No 32) Does your child have any special problems not listed above? If so, list on the back.

33) When was your child's last doctor visit? Month_____ Year_____

Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Guardian/Caregiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's teacher in assessing their health and development, and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

All information indicated on this Health History questionaire is confidential.