HEALTH HISTORY/ STRENGTHS AND NEEDS ASSESSMENT

Child's Name: _____ DOB: _____ Age: _____

Age the child walked at _____ began talking _____ began toilet training: _____

Is the child suffering from a physical or mental illness? ☐ YES ☐ NO

If yes, describe _____

Is the child in counseling? ☐ YES ☐ NO

Does the child suffer from any allergies? (Ex: food, medication, seasonal) ☐ YES ☐ NO

If yes, please describe? _____

Parent's/legal guardian's/foster parent's evaluation of child's physical health? _____

Parent's/legal guardian's/foster parent's evaluation of child's overall personality and emotional health?

_____

How does the child get along with his/her parents? Siblings? Peers? _____

Does the child experience any phobias or fears? _____

Are the child's immunizations current? _____

What is your alternate plan when child is ill and cannot attend regular daycare/school? _____

_____

Do you have a support system (family/friends/coworkers) who you rely on in times of need?

☐ YES ☐ NO

If yes, please elaborate _____

Do you have any concerns for your child in the following areas?

☐ Hearing ☐ Vision ☐ Speech/language

☐ Learning/cognitive development ☐ Physical development ☐ Behavioral/emotional development

Other: _____

We offer referrals to assist with the following: (Please indicate what referrals interest you).

☐ Food Assistance ☐ Housing ☐ Health/immunizations/dental services

☐ Legal Assistance ☐ Employment/Budgeting ☐ Parenting Education/Information

☐ Mental Health Counseling ☐ Domestic Violence ☐ Substance Abuse Counseling

What is the primary language spoken in the home? _____

_____ _____

Parent/Legal Guardian/Foster Parent signature **Date**

For CCCC USE ONLY--- **Referrals Given**: _____