Family History Questionnaire

Child's Last Name:	Middle Initial:	First Name:	Date of Birth:

#1-☐ Parent ☐ Guardian ☐ Foster Parent Name:	#2-☐ Parent ☐ Guardian ☐ Foster Parent Name: ☐ Check here if you'd like additional results sent to this parent/guardian.
Address:	Address:
Mailing Address (if different):	Mailing Address (if different):
Primary Phone Number:	Primary Phone Number:
Alternate Phone Number:	Alternate Phone Number:
Email Address:	Email Address:
Best way to contact family: ☐ *phone* ☐ *email*	Best way to contact family: ☐ *phone* ☐ *email*
Other children living in household: Name: ______________ D.O.B.: ________ Name: ______________ D.O.B.: ________ Name: ______________ D.O.B.: ________	Other children living in household: Name: ______________ D.O.B.: ________ Name: ______________ D.O.B.: ________ Name: ______________ D.O.B.: ________
Who does the child live with?	Child's Primary Language

Has your child's hearing been tested? ☐ Yes ☐ No
When/by whom: ____________________

Has your child had 3 or more ear infections? ☐ Yes ☐ No
Does your child have tubes? ☐ Yes ☐ No

Do you have concerns about your child's hearing? ☐ Yes ☐ No
List concerns: ____________________

Has your child's vision been tested? ☐ Yes ☐ No
When/by whom: ____________________

Do you have concerns about your child's vision? ☐ Yes ☐ No
List concerns: ____________________

Does your child wear glasses? ☐ Yes ☐ No

Additional Relevant Health Information:

Please complete reverse side.

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Does your child currently receive Special Education services? ☐Yes ☐No

Did your child receive Early Intervention services? ☐Yes ☐No

Do you have any concerns with your child's development? (Please explain)

What things are difficult for your child?

Does your child currently attend preschool? ☐Yes ☐No Name of Preschool: ___________________________

Times attending:				
	Monday	________	☐AM	☐PM *(please check all that apply)*
	Tuesday	________	☐AM	☐PM
	Wednesday	________	☐AM	☐PM
	Thursday	________	☐AM	☐PM
	Friday	________	☐AM	☐PM

Please list anything else you would like us to know about your child's developmental history or family.

Name of person completing this form: ___________________________

Relationship to child: ___________________________

THANK YOU

RI Child Outreach Screening does not discriminate on the basis of age, sex, sexual orientation, race, religion, national origin, color or disability in accordance with applicable state laws and regulations.