COMMUNITY ACTION ORGANIZATION

PROGRAM APPLICATION

APPLICANT _____

SS# _____ / _____ / _____ PHONE (day) _____ _____ (eve) _____

STREET ADDRESS _____ APT.# _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ EMERGENCY PHONE _____

TYPE ☐ CPL ☐ EXT ☐ FEM. H ☐ IND. F ☐ IND. M ☐ MALE H ☐ 2-PARENT

HOUSING ☐ Rent Amt._____ ☐ Own ☐ Mobile ☐ Subsidized ☐ Homeless
☐ Farm Labor ☐ Shared ☐ Multi-unit ☐ Heat Incl.
☐ WX Done ☐ WX Needed

HOMELESS ☐ Formerly ☐ Homeless/Cause _____ Zip _____

HEAT ☐ Oil ☐ Gas ☐ Propane ☐ Electricity ☐ Wood ☐ Other

SOURCE OF CONTACT _____

TOTAL HOUSEHOLD INCOME _____ **TOTAL # IND** _____

APPLICANT

DOB _____ / _____ / _____

M ☐ F ☐

HOW VERIFIED INCOME: _____

INCOME (APPLICANT)

M / Q / Y	ANNUAL	SOURCE
TOTAL		

EMPLOYMENT FE FF FT MF NO PT RE SE SF TS TW UN

DEMOGRAPHICS **Ethn.** A BL H MX NA NR OT WH

Lang 1 _____ 2 _____ **Ed:** _____ **Vet:** ☐ **Disability:** M / P / T / Home

BENEFITS FS ADC SS SSD SSI RET GA VA OHP

By signing this form, I declare that all information provided for purposes of establishing program eligibility is true and correct to the best of my knowledge. I hereby authorize Community Action (CAO) or its agents access to any records necessary to verify information given.

Applicant _____ Date _____

WCCAO Representative _____ Date _____

COMMENTS _____

SERVICE CODES:	UNITS:	UNITS:	UNITS:

PROGRAM APPLICATION: FAMILY/HOUSEHOLD INFORMATION

APPLICANT ______________________________ Page____of____

NAME

First ____ MI ____ Last ____

M ☐ F ☐

SS#_______/_______/_______ DOB____/____/____

HOW VERIFIED ______________________

INCOME		
M / Q / Y	ANNUAL	SOURCE
TOTAL		

EMPLOYMENT FF FT MF NO PT RE SE SF TS TW UN

DEMOGRAPHICS Ethn.: A BL H MX NA NR OT WH

Lang 1__________ 2__________ Ed__________ Vet ☐ Dis: M / P / T / Home

BENEFITS: FS ADC SS SSD SSI RET GA VA OHP

NAME

First ____ MI ____ Last ____

M ☐ F ☐

SS#_______/_______/_______ DOB____/____/____

HOW VERIFIED ______________________

INCOME		
M / Q / Y	ANNUAL	SOURCE
TOTAL		

EMPLOYMENT FF FT MF NO PT RE SE SF TS TW UN

DEMOGRAPHICS Ethn.: A BL H MX NA NR OT WH

Lang 1__________ 2__________ Ed__________ Vet ☐ Dis: M / P / T / Home

BENEFITS: FS ADC SS SSD SSI RET GA VA OHP

NAME

First ____ MI ____ Last ____

M ☐ F ☐

SS#_______/_______/_______ DOB____/____/____

HOW VERIFIED ______________________

INCOME		
M / Q / Y	ANNUAL	SOURCE
TOTAL		

EMPLOYMENT FF FT MF NO PT RE SE SF TS TW UN

DEMOGRAPHICS Ethn.: A BL H MX NA NR OT WH

Lang 1__________ 2__________ Ed__________ Vet ☐ Dis: M / P / T / Home

BENEFITS: FS ADC SS SSD SSI RET GA VA OHP

NAME

First ____ MI ____ Last ____

M ☐ F ☐

SS#_______/_______/_______ DOB____/____/____

HOW VERIFIED ______________________

INCOME		
M / Q / Y	ANNUAL	SOURCE
TOTAL		

EMPLOYMENT FF FT MF NO PT RE SE SF TS TW UN

DEMOGRAPHICS Ethn.: A BL H MX NA NR OT WH

Lang 1__________ 2__________ Ed__________ Vet ☐ Dis: M / P / T / Home

BENEFITS: FS ADC SS SSD SSI RET GA VA OHP

WASHINGTON COUNTY COMMUNITY ACTION ORGANIZATION
EMERGENCY SHELTER PROGRAM INTAKE

(circle one)
WCCAO SHELTER
MOTEL
TCM
OTHER_____

2

ATE: _____ STAFF: _____

AMILY NAME: _____

AST PERMANENT RESIDENCE: _____
city state date you left this residence

THE FOLLOWING QUESTIONS ARE ASKED IN ORDER TO PROTECT THE SAFETY AND SECURITY OF ALL SHELTER RESIDENTS. YOUR COOPERATION IS APPRECIATED

ICES ANYONE IN YOUR FAMILY HAVE ANY COMMUNICABLE ILLNESS? YES NO
NAME ILLNESS COMMENTS

S ANYONE IN YOUR FAMILY CURRENTLY RECEIVING MENTAL HEALTH TREATMENT OR COUNSELING OR HAVE A HISTORY OF MENTAL HEALTH PROBLEMS? YES NO
NAME EXPLANATION (dates, reasons, outcomes, etc.)

MEDICATIONS CURRENTLY BEING TAKEN FOR any REASON.
NAME MEDICATION DOSAGE REASON

SHELTER POLICY PROHIBITS DRINKING ALCOHOL OR TAKING ILLEGAL DRUGS ON AND OFF THE PREMISES WHILE YOU ARE STAYING IN THE SHELTER. ARE ALL MEMBERS OF YOUR FAMILY WILLING AND ABLE TO STAY COMPLETELY CLEAN AND SOBER FOR 21 DAYS? YES NO

HAS ANYONE IN YOUR FAMILY BEEN IN TREATMENT FOR SUBSTANCE ABUSE? YES NO

WHO? _____ WHEN? _____ WHERE? _____

COUNSELOR NAME _____ PHONE: _____

WHAT ALCOHOL AND/OR NON-PRESCRIPTION DRUGS WERE USED BY ANY FAMILY MEMBER IN THE LAST 30 DAYS?
NAME ALCOHOL/DRUG AMOUNT HOW OFTEN?

WHEN DID YOU HAVE YOUR LAST DRINK? _____
HAS ANYONE IN YOUR FAMILY BEEN CONVICTED OF A CRIME? YES NO
NAME CHARGE DATE LOCATION

P.O. NAME PHONE CITY CO. ST.

Community Action Organization
Emergency Family Shelter
Prescreening Form

Date_____

** Make sure you are speaking to the head of household.

Client's Name_____ Tel. Contact #_____

1. Can you please describe your situation and why you and your family are in need of shelter?

   Explanation:

2. Are you or any family member currently fleeing a domestic violence situation? **Y N**

   Explanation:

3. Have you or any family member stayed in a shelter within the year? **Y N**

   ** If answered yes, Have you or any family member been evicted from another shelter? **Y N**

   Name/Where: _____

   Contact #: _____

   Explanation:

4. How many persons need shelter in your family? _____
   What are the ages and sex of the children?

   age____ M F age____ M F
   age____ M F age____ M F
   age____ M F age____ M F

5. Can you please give an estimate of your families monthly income?

   AFS $ _____ Employment_____

   Food Stamps $ _____

10. Have you or any family member been in a drug or alcohol treatment program? **Y N**

Name/Where _____

Contact person & #: _____

Date/Year: _____

Explanation:

** If answered yes, how long have you/ family member been clean and sober?_____

** Shelter rules do not include housing people with drug or alcohol problems, residents are not permitted to drink or use drugs during their stay.

11. Briefly explain our Shelter Program to the head of household. Important things to mention are:

Five week stay
Chores - 2 per adult daily
Shelter hours - when residents are required to leave shelter
No drugs or alcohol
Child supervision

** Shelter residents are required to participate in the following programs:

Case Management
Tenant Education Class
Parenting Class

12. If any red flags, ask for additional information:

Date of Birth: _____

Social Security #: _____

_____

Intake staff signature

WASHINGTON COUNTY COMMUNITY ACTION ORGANIZATION
EMERGENCY SHELTER PROGRAM

4

TO BE COMPLETED BY CASE MANAGER AT 2nd DAY INTAKE

CASE MANAGER: _____

DATE: _____

LIST ALL FAMILY MEMBERS BELOW

NAME (FIRST AND LAST)	M/F	AGE	VETERAN Y/N	CURRENTLY WITH YOU?

TWO PEOPLE WHO WILL ALWAYS KNOW WHERE TO REACH YOU:

NAME: ADDRESS PHONE

_____

_____

EMERGENCY NEEDS

- ☐ FOOD
- ☐ CHILD ABUSE
- ☐ MEDICAL
- ☐ CLOTHING
- ☐ OTHER
- ☐ DOMESTIC VIOLENCE
- ☐ TRANSPORTATION
- ☐ FURNITURE
- ☐ MENTAL HEALTH

HOUSING INFORMATION

WHAT HAPPENED TO MAKE YOU HOMELESS NOW?

HOW MANY TIMES HAVE YOU MOVED IN THE PAST YEAR? _____

WHAT ARE YOUR HOUSING NEEDS? (size, location, special needs, amount of rent, etc.)

WHAT ARE YOUR PLANS FOR LOCATING HOUSING?

HEALTH INFORMATION

DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO

WHAT TYPE? ☐ PUBLIC_____ ☐ PRIVATE _____

WHO DOES IT COVER? _____

ARE YOUR CHILDREN IMMUNIZED? ☐ YES ☐ NO

WHAT SPECIFIC NEEDS OR CONCERNS DO YOU HAVE ABOUT THE HEALTH OR WELLBEING OF ANY FAMILY MEMBER? (Illness, disability, depression, substance abuse, anger or violent behavior, etc.)

EMPLOYMENT INFORMATION

ARE THE ADULTS IN YOUR FAMILY EMPLOYED?

NAME	OCCUPATION	LOCATION

IS ANYONE LOOKING FOR WORK? ☐ YES ☐ NO IF YES, WHO? _____

WHAT WORK ARE THEY INTERESTED IN DOING?

WHAT WORK HAVE THEY DONE IN THE PAST?

IS THERE WORK THEY CANNOT OR DO NOT WISH TO DO?

EDUCATION INFORMATION

EDUCATIONAL LEVEL OF THE ADULTS IN THE FAMILY (write in names in appropriate spaces)

K-8TH GRADE	
9-12TH (non HS grad.)	
HS GRAD/GED	
POST SECONDARY	

ARE THE ADULTS IN YOUR FAMILY ABLE TO READ THE NEWSPAPER IN ENGLISH? ☐ YES ☐ NO

ARE YOUR SCHOOL-AGE CHILDREN ENROLLED IN SCHOOL NOW? ☐ YES ☐ NO

NAME	GRADE	SCHOOL, LOCATION	COMMENTS

FAMILY INFORMATION

DOES ANYONE IN YOUR FAMILY NEED AN INTERPRETER FOR SPEAKING ENGLISH? ☐ YES ☐ NO WHO? _____

IN HARD TIMES, WHO IS MOST SUPPORTIVE AND THE MOST HELP TO YOU WHEN YOU NEED IT? (Check all that apply)

- ☐ FAMILY (who?) .....
- ☐ FRIENDS (who?)
- ☐ CHURCH .....
- ☐ SOCIAL SERVICE AGENCIES (Which ones?)
- ☐ OTHER (who?) .....

WHAT KIND OF HELP AND SUPPORT DO YOU GET? WHAT DO YOU NEED? .....

.....

.....

.....

WHAT EFFECT HAS BEING HOMELESS HAD ON YOUR FAMILY? .....

- ☐ LOSS OF CHILDREN .....
- ☐ DISCIPLINE PROBLEMS
- ☐ EMOTIONAL PROBLEMS (For example, depression, anxiety, sleep problems, appetite changes, etc) .....
- ☐ CHILDREN HAVE TROUBLE LEARNING
- ☐ VIOLENT OR ANGRY BEHAVIOR .....
- ☐ INCREASED USE OF DRUGS AND/OR ALCOHOL
- ☐ OTHER .....

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOU AND YOUR FAMILY? WHAT ARE YOUR FAMILY'S STRENGTHS?

.....

.....

.....

.....

.....

SIGNATURE OF AT LEAST ONE ADULT FAMILY MEMBER: _____ DATE: _____

_____ DATE: _____

'zation #:

Applicant Name: _____ Agency: _____
(Last, First)

OREGON HOUSING AND COMMUNITY SERVICES DEPARTMENT
LOW-INCOME ENERGY ASSISTANCE PROGRAM AUTHORIZATION FORM

CLIENT INFORMATION

Regular Authorization Number (use for Crisis only):

Previous Authorization Date:

Ref.	SSN	Name	Sex	Birth Date	Language	Applicant	Disabled P/T	Homebound	Farm Worker	Veteran	Ethnic Group	Food Stamps	AFDC	SSI	Social Security	Pension	GA	VA
A																		
B																		
C																		
D																		
E																		
F																		

Language Codes

E	English
S	Spanish
RU	Russian
V	Vietnamese
C	Chinese
A	American Sign
AR	Arabic
F	Farsi
H	Hmong
K	Khmer
KO	Korean
L	Laotian
M	Mien
MA	Mayan Group
RO	Romanian

Ethnic Group Codes

W	White
AF	African-American
H	Hispanic
NA	Native American
AS	Asian American
P	Pacific Islander
M	Mixed Race
NO	No Response

EMPLOYMENT

Ref.	Employer	Address	City	State	Zip	Phone

INCOME

Ref.	Income Source	Type	Frequency	Amount	Annual	Comments / Verification

DEDUCTIONS

Ref.	Expense Source	Type	Frequency	Amount	Annual	Comments / Verification

PROGRAM (LIEAP 95):

Payment Type: ____

1 Regular
2 Crisis
Other:
3 Sub-Half
4 Roomer Boarder/ Owner 1/2
5 Sub-Special
6 Hotel
7 Special

Intake Date:	Subsidized (Y/N):	Authorized Amount:	Total Annual Income:
Eligible # in Household:	Weatherization (Y/N):	Direct Pay Amount:	Less Deductions:
			Adjusted Annual Income:
			Comments:

Vendor	Name on Account	Account Number	Amount

Authorization #:

Applicant Name: _____ (Last, First) Agency: _____

RESIDENCE INFORMATION

Street Address: | Apt. or Space #:

Address Line 2:

City: | State: | Zip: | County:

Type of Dwelling: [ ] Enter Value from List below

- **H** House
- **M** Multiple Units (2-4)
- **U** Multiple Units (Over 4)
- **O** Mobile Home
- **A** Manufactured Home
- **E** Hotel
- **T** Travel Trailer
- **R** Other

Residence Status: [ ] Enter Value from List below

- **R** Rent (Heat not included)
- **E** Rent (Heat included)
- **O** Own
- **S** Subsidized Housing (Heat not included)
- **U** Subsidized Housing (Heat included)

Types of Heat:

- [ ] **E** Electric
- [ ] **N** Natural Gas
- [ ] **O** Oil
- [ ] **L** Liquid Gas
- [ ] **W** Wood
- [ ] **P** Pellet
- [ ] **T** Other

Primary Heat Type: [ ] Enter Value from list above

Comments:

HOUSEHOLD

Mailing Address: | Apt. or Space #: | Hold at Agency

Address Line 2: | POB: | [ ] Checks

City: | State: | Zip: | Phone: | M/H/W: | [ ] Mail

Comments:

APPLICANT DISCLAIMER:

I have not received LIEAP under this program since October 1, 1995. By signing this form, I hereby authorize Oregon Housing and Community Services Department (HCS) or its agents, access to any records in order to verify information given. I also consent to any legally authorized investigation for confirmation of that information. I agree to let Adult and Family Services give information to HCS or its agents, so that I can get energy assistance. I am aware that my fuel supplier will receive a copy of this document,

If I receive assistance to which I am not entitled as a result of withholding information or knowingly giving fraudulent information, I must repay that assistance and may be found guilty of fraud and fined up to $10.000 or put in prison or both. I understand that no person may be denied assistance on the basis of race, color, sex, age, handicap, religion, national origin or political belief. I further understand that if my application is unjustly denied or is not processed in a timely manner that I may be entitled to a fair hearing, if requested within 30 days of the completed date of the application or date of denial.

[ ] Approved [ ] Denied

Applicant Signature: _____ Date

App icant Signature: _____ Date

Intake Worker Signature: _____ Date

Agency Certification: The above named applicant has met the income eligibility requirements of the State of Oregon Low Income Energy Assistance Program and is authorized to receive assistance in the amount above.

Authorizing Agency Signature: _____ Date

Data Entry: _____ Date

INPUT DOCUMENT

FAIR HOUSING CONTACT SHEET

A:\F&E92-93frhs

6

PROTECTED CLASS: _____

DATE:

NAME: PHONE:

ADDRESS:

LOW INCOME: ☐ YES ☐ NO PUBLIC ASSISTANCE: ☐ YES ☐ NO

SITUATION:

PLAN OF ACTION:

7

WASHINGTON COUNTY COMMUNITY ACTION ORGANIZATION (WCCAO)
FAMILY SELF-SUFFICIENCY ASSESSMENT

FAMILY MEMBERS DATE: _____

Name: _____ S.S. # _____ D.O.B. _____
Name: _____ S.S. # _____ D.O.B. _____
Name: _____ S.S. # _____ D.O.B. _____
Name: _____ S.S. # _____ D.O.B. _____
Name: _____ S.S. # _____ D.O.B. _____
Name: _____ S.S. # _____ D.O.B. _____
Address: _____ City: _____ Phone: _____
Emergency Contact name & phone number: _____

1. HOUSING ASSESSMENT

Amount of Rent/Mortgage: _____ Subsidized? ____ Yes ____ No

A. If subsidized, how long? _____
B. Is the space adequate? _____
C. Is the heating adequate? _____
D. Are there any maintenance or weatherization needs? _____
E. Are the furnishings adequate? _____
F. Percentage of monthly income spent on rent? _____
G. How many times have you:
   1. Moved (in the last twelve months?) _____
   2. Ever been late with your rent or payment? _____
   3. Ever received an eviction notice? _____
   4. Ever had a utility shut-off notice? _____
   5. Ever had your utilities disconnected? _____
H. How many times has your family been homeless? _____
   When? _____ Where? _____
I. Describe your experience with homelessness. _____
   _____
   _____
J. Action needed to improve housing status? _____
   _____
   _____

2. EDUCATION ASSESSMENT

A. Where did the adults attend school? _____
B. Highest grade completed for all adults? _____
C. Have you received any specialized training? _____
   _____
D. What skills have you acquired through on-the-job training or life experience? _____
   _____
E. What are your educational or training goals? _____
   _____

F. Current obstacles to achievement? _____

_____

G. Action needed to achieve goals? _____

_____

_____

_____

EMPLOYMENT ASSESSMENT

A. Immigration status of adults in the family? _____

_____

B. Are adults currently employed outside the home? _____
Where? _____

C. If yes, job title and description of duties: _____

_____

D. Past employment: _____

_____

E. What is your current work schedule? _____

F. How long have you been employed? _____

G. Employment History:
1. Number of jobs held in the past year? _____
2. Did you receive unemployment during the past year? _____

H. Occupational Skills: _____

I. Work shift preference: _____

J. Travel limitations: _____

K. Employment goals: _____

_____

L. Do you feel there are any obstacles to goal achievement? _____

_____

M. Action needed to achieve goals: What assistance can we offer to help you achieve your goals? _____

_____

_____

_____

_____

4. PHYSICAL HEALTH ASSESSMENT
(Mark with an "X" those items that you have experienced and describe briefly, if necessary.

A. Physical exam within the last two years ____Mother ____Father
B. Visual treatment
C. Hearing treatment
D. Dental treatment
E. Diabetes
F. Operations
G. Broken bones
H. Injuries
I. Significant illnesses

J. Allergies
K. Handicaps
L. Currently on medication
M. Comments regarding any of the above mentioned items: _____

_____

_____

N. Overall physical health/concerns regarding any of the above: _____

_____

_____

O. Do you have medical insurance? _____

_____

P. Action needed to improve physical health: _____

_____

_____

_____

5. MENTAL HEALTH ASSESSMENT

(Mark with an "X" those items that you have experienced and describe briefly, if necessary.)

	Mother	Father
A. Mental Illness?		
B. Sexual Abuse?		
C. Physical Abuse?		
D. Emotional Abuse?		
E. Suicide thoughts/attempts?		
F. Any treatment plans?		

G. Action needed to improve mental health? _____

_____

_____

_____

_____

6. SUBSTANCE ABUSE ASSESSMENT

A. Is there a history of drug/alcohol abuse in the family?
If so, by whom? _____
Please explain: _____

_____

B. Involved in a treatment program? _____
C. Have you received a DUII or substance abuse related charge? _____
D. Action needed to improve in this area? _____

_____

_____

_____

7. LEGAL ASSESSMENT

A. Driver License status: _____
B. Mode of transportation: _____
C. Car insurance: _____
D. History of criminal involvement? Who? What? Where? _____
_____
_____
E. Probation/Parole Officer: _____
F. Action needed to improve legal status _____
_____
_____
_____

8. CHILDREN'S WELL BEING ASSESSMENT
(Refer to Physical and Mental Health Assessment for adults. Ask specific questions regarding each child.)

Name: _____ Age: ____ Born in the U.S____ School/Grade _____
Special concerns regarding child: _____
_____
Name: _____ Age: ____ Born in the U.S____ School/Grade _____
Special concerns regarding child: _____
_____
Name: _____ Age: ____ Born in the U.S____ School/Grade _____
Special concerns regarding child: _____
_____
Name: _____ Age: ____ Born in the U.S____ School/Grade _____
Special concerns regarding child: _____
_____

9. OTHER PERTINENT INFORMATION

Describe any other pertinent information regarding the family: _____
_____
_____
_____
_____

Date																
#in HH																
Female HH																
Senior (60+)																
Farmworker																
Non-English																
Z																
I 97---																
P																
Child Care																
Clothes																
Dental																
Disability																
Domestic Vio.																
Donating																
Education																
Employment																
Energy																
Fair Housing																
Financial																
Food																
General																
Head Start																
Holiday																
Home Repair																
HouseholdGoods																
Housing																
House Locator																
Legal																
Medical																
Mental Health																
Parenting																
Public Agencies																
Rent Assistance																
Senior Services																
Training																
Translation																
Transportation																
Travel																
Utilities																
Volunteer																
WX																
Youth Services																
SH Last Zip																
E If not known,																
L list town or																
T state.																
E																
R (Fam, Cpl, Ind)																

Other (list)

Community Action Organization

HEAD START PROGRAM INFORMATION

9

CHILD: _____ **CENTER 1:** _____

CENTER 2: _____

RETURNING FAMILY: ☐ YES ☐ NO

ENROLLMENT CRITERIA:

IMMUNIZATION RECORD? ☐ YES ☐ NO MEDICAL CARD # _____

☐ EARLY INTERVENTION

☐ SCF (CSD): _____ ☐ TRANSFER FROM: _____ ☐ EVEN START: _____

COMMENTS/CONCERNS _____

_____

DAY CARE INFORMATION:

Provider Name: _____ **Phone:** _____

Address: _____

PARENT/GUARDIAN INFORMATION:

Name: _____

Address: _____

City/Zip: _____

Phone: _____

Reporting Information: (for reporting purposes only)

in Family _____ # Male Children _____ # Female Children _____

HH Type _____ Both Employed: ☐ Yes ☐ No

Is the primary wage earner employed FT (more than 35 hours per week) ☐ Yes ☐ No

PT ☐ Yes ☐ No Other _____

Mother: <18: ☐ Yes ☐ No 19 - 22: ☐ Yes ☐ No <18 at birth oldest child ☐ Yes ☐ No

GED or HS Equivalent: ☐ Yes ☐ No

Father: GED or HS Equivalent: ☐ Yes ☐ No

LOCATION OF HOME: **(Name of apt., closest major streets)**

_____

_____

Date: _____ **CAO Representative:** _____

WHITE: MAIN OFFICE YELLOW: CENTER

10

WASHINGTON COUNTY HEAD START
1001 SW Baseline
Hillsboro, Oregon 97123

HEALTH HISTORY

PLEASE TAKE YELLOW COPY WITH YOU TO PHYSICAL EXAM

FOR STAFF USE: FOLLOW-UP NEED IN THESE SECTIONS:	
___Pregnancy and Birth	___Health
___Early Life	___Dental
___Child's Diseases	___Nutrition

Child's Name_____

Date of Birth_____

PREGNANCY AND BIRTH:

	Yes	No	Comments
Birth Weight_____			
Did you see a doctor regularly?	_____	_____	_____
Any problems with the pregnancy?	_____	_____	_____
Was the baby born early or late?	_____	_____	_____
Were there any problems with labor or delivery?	_____	_____	_____
Did the baby stay in the hospital longer than mother?	_____	_____	_____

EARLY LIFE:

As an infant this baby was: ☐Overactive ☐Quiet ☐Irritable ☐average
Sleep Habits: ☐Slept well ☐Hardly slept ☐Other (describe)_____
_____

Feeding: ☐Normal ☐Problems (what kind?) ☐Sucking ☐Swallowing ☐Eating enough ☐Food sensitivity (allergy)

CHILD'S DISEASES:

Has your child ever had a serious illness? Yes _____ No

Does your child have any allergies to:
Food Yes_____ No
Bee Stings Yes No
Medication Yes_____No
Other_____ _____

What symptoms does your child have as a result of an allergic reaction:_____

Has your child ever been hospitalized? Yes No Overnight? Yes No

Dates _____ **Reason** _____

_____ _____

Does your child have any chronic (on going) medical conditions? (example: asthma)_____

Does your child have immune system problems or frequent illness/infections? _____Yes ____No

Does your child take any medicines? (If Yes, list):_____

_____

WHITE COPY: CHILD'S FILE YELLOW COPY: PHYSICIAN

CHILD'S HEALTH:

	Yes	No	Comments
Eyes			
Has your child ever had any trouble seeing?	____	____	
Have your child's eyes ever been tested?	____	____	
Does your child sit very close to the T.V.?	____	____	____
Ears			
Has your child ever had frequent ear infections?	____	____	
Has your child had any trouble hearing?	____	____	
Has your child's hearing ever been tested?	____	____	
Does your child turn the T.V. up very loud?	____	____	____
Throat			
Has your child had any trouble swallowing?	____	____	
Has your child had frequent sore throats or strep throat?	____	____	____
Heart			
Has a heart murmur ever been heard on your child?	____	____	
Has your child ever had a "blue spell" or swollen ankles or joints?	____	____	____
Lungs			
Has your child ever had pneumonia?	____	____	
....Tuberculosis?	____	____	
Has your child ever coughed up blood?	____	____	____
Abdomen			
Child ever had frequent vomiting or diarrhea?	____	____	
..... Yellow Jaundice?	____	____	
..... Frequent stomach pains?	____	____	
..... Marked weight loss?	____	____	
..... Blood in bowel movements?	____	____	
..... Black bowel movements?	____	____	
Does your child soil his/her pants?	____	____	____
Urinary Tract			
Does your child have any pain/burning when urinating?	____	____	
Does your child wet the bed at night?	____	____	
Does your child wet his/her pants?	____	____	____
Extremities			
Has your child ever had weakness, limp, or paralysis of arms or legs?..	____	____	
Has your child ever broken a bone?	____	____	____
Neurological			
Child ever had fainting or blackout spells?	____	____	
..... Frequent headaches?	____	____	
..... Dizzy spells?	____	____	
..... Seizures?	____	____	____
Behavior			
Is your child able to separate easily from you to go to day care, relative's home, etc.?	____	____	____
Does your child have any specific fears?	____	____	____
Do you have any concerns about your child's behavior?	____	____	____