FORM D

Stockbridge-Munsee Community | Electa Quinney Head Start
BEHAVIORAL HEALTH-HEAD START SCREEN

Today's Date

Parent/Guardian Name: **Child's Full Name:**

With whom Does the Child Currently Live

Has the Child Lived with Anyone Else in the Past ☐ - Yes ☐ - No ☐ - Unsure

Pregnancy and Delivery Complications ☐ - Yes ☐ - No ☐ - Unsure

Please Explain

Did the Child Reach Developmental Milestones at a Typical Age

Slept Through the Night ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Sat Alone ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Crawled ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Stood Alone ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Walked without Help ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Said First Words ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Spoke in Simple Phrases ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Toilet Trained – Day ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Toilet Trained – Night ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Used Crayons ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

Understood What is Said to Him/Her ☐ - Yes ☐ - No ☐ - Unsure
If No, Please Explain

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How Does the Child Get Along with Adults

How Does the Child Get Along with Peers

Who Does the Child Spend the Most Time with

What are the Child's Hobbies and Interests

Is there a Behavior Problem at Home ☐ - Yes ☐ - No ☐ - Unsure

If Yes, Please Explain

What Kind of Discipline is Used with the Child

Who is the Primary Disciplinarian

Is the Child Experiencing any Problems in School

Academics (Grades) ☐ - Yes ☐ - No

If Yes, Please Explain

Behavior ☐ - Yes ☐ - No

If Yes, Please Explain

Social (Peers or Adults) ☐ - Yes ☐ - No

If Yes, Please Explain

Behavioral Health Signature: **Date:**

Head Start Staff Review

Head Start Signature: **Date:**