LCCS Clinic
Home Visit Health Questionnaire

Child's Name	DOB	SACWIS Case ID	Nurse Initials

Type of Placement

☐Relative Home ☐Foster Home ☐Medical Facility ☐Residential ☐Group Home

Concerns/Illnesses/Treatments/ER Visits

Special Equipment

Medication	Dose	Frequency

Medical Follow Up

Nutrition

Sleep

Toileting

Behaviors

Teaching/Education Provided

☐Birth Control
☐Care Basics
☐Community Resources
☐Development
☐Dental
☐Other:
☐Hygiene
☐Medication
☐Nutrition
☐Safety
☐Shaken Baby
☐SIDS
☐Skin Care
☐Sleep Habits
☐Smoking

Recommendations/Comments