

Child's name: \_\_\_\_\_

Allergies: \_\_\_\_\_

For the form below, mark with an "X" all that applies.

**Social History:**  No change from last visit  
With whom does the child live with most of the time:  
 Both parents in the same household  
 Father  Stepmother  Stepfather  Mother  
 Guardian  Brother(s)/Sister(s)

Have you ever had to avoid health care for your child due to any of the following:  
 Transportation  
 Money  
 Inconvenient

**Primary Drinking Water:**  
 Well  
 City/Municipal  
 Contains fluoride

**Child Health History:** Check any problems that the child has had with the following:  
 Measles, Mumps, Rubella  Asthma  Seizures  Any Surgeries  
 Chicken Pox  Exposure to Tb or Person  Meningitis  Fatigue  
 Frequent Colds  with Chronic Cough  Elevated Blood Lead Level  Other  
 Ear Infections  Heart Murmur  Physical Abuse or Neglect  
 Strep Throat  Rheumatic Fever  Any Known Chronic Diseases

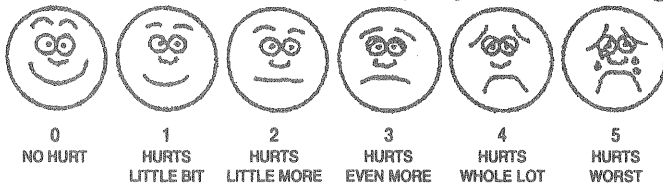
How often has your child been to the emergency room in the past year: \_\_\_\_\_ Explain: \_\_\_\_\_

**Family Health History:** Check all that apply to the *immediate* family (parents, aunts/uncles, siblings, grandparents)  
 No change from last visit  
 Diabetes  Heart Disease  Obesity  High blood pressure  Elevated cholesterol  Cancer  
 Kidney disease  Blood disorder  Tuberculosis  Asthma  Allergies  Seizures  
 Thyroid problems  Mental illness  Drug use  Alcohol use  Tobacco use  Suicide  
 Eating disorders  Mental retardation  Sexually transmitted diseases  Allergies  Other

**Dental History:**  Seen dentist in last six months  Problems with gums  
 Aware of brushing teeth at least two times a day  Problems with cavities

**Immunizations:**  
Immunization record available:  
 Yes  No  
Are immunizations up-to-date:  
 Yes  No

Please circle the face that matches the pain your child is having today.



**Records Requested**

**Hospitalizations:**      When \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any concerns regarding domestic violence or child abuse/neglect?  
YES      NO

**Developmental/Psychosocial History:**  
**Feelings:** Everyone is sad sometimes, but if your child is sad more than you think is normal, check "sad".  
 Restless  
 Sad  
 Guilty  
 Irritable  
 Sullen  
 Fearful  
 Lonely  
 Anxious  
 Angry  
 Self Critical  
 Lots of crying  
 Feeling out of control

**Behavior:**  
 Impulsive  
 Fire-Setting  
 School Problems  
 Threatens/Harms Others  
 Overactive  
 Suicidal  
 Sexual Acting Out  
 Sexual Offenses  
 Self-Destructive  
 Stealing  
 Tortures Animals  
 Compulsive Lying  
 Substance Abuse  
 Destroys Property

**Social Interactions:**  
 Withdrawn  
 May Cling A Lot  
 Difficulty Making/Keeping Friends  
 Aggressive  
 Defiant  
 Argues A Lot  
 Acts Too Young  
 Victimized  
 Disobedience, May Involve Legal Violations

**Current Medications:** List name(s) of medication(s) the child is currently taking. Include vitamins, supplements, herbs, and oxygen:

**Thinking:**  
 Frequently Confused  Bizarre Ideas  Suicide Ideas  
 Daydreams A Lot  Blames Others  Mistrustful  
 Frequent Memory Loss  Out of Touch With Reality  
 Problems Concentrating/Paying Attention  
 Obsessive  
 Distracted  Delusions