

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 **Primary Drinking Water:**
 Money Well
 Inconvenient 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 with chronic cough Meningitis Other
 Frequent Colds Elevated Blood Lead Level
 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

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



0 NO HURT 1 HURTS LITTLE BIT 2 HURTS LITTLE MORE 3 HURTS EVEN MORE 4 HURTS WHOLE LOT 5 HURTS WORST

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

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 Withdrawn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