Hope & Wellness Rising

Grow *through* Challenges

Today's Date: _____

CHILD HEALTH HISTORY FORM

Child's Name: _____ Date of Birth: _____

Name of Person Completing Form: _____Relationship to Child: _____

Why are you seeking help for your child? _____

_____

Please list some of your child's strengths (personality, social, talents, academic, etc.): _____

_____

Please list some of your family's strengths: _____

_____

Parent's/Guardian's Name: _____ Age: _____

Occupation/ Employer: _____ Highest Education Completed: _____

Parent's/Guardian's Name: _____ Age: _____

Occupation/ Employer: _____ Highest Education Completed: _____

Other Primary Caregivers: _____

Custody arrangement if parents separated/divorced: _____

List other children living in the home and any siblings living outside of the home:

Name	Age	Gender	Relationship to Child	Living at Home?

Number of family moves since your child was born: _____ Any foster care placements? _____Yes _____No

Other family or residential placements? _____Yes _____No If yes, please describe: _____

Developmental/ Social/ Medical History

Instructions: Please read each question and mark an "X" in the appropriate box and add comments as needed.

Was your child adopted? _____ Yes _____No If yes, is your child aware of the adoption? _____Yes _____No

At what age was your child adopted? _____

<u>Mother's Pregnancy with Child</u>:

Delivery: _____Vaginal _____C-Section Labor Induced: _____Yes _____No Forceps Used: _____Yes ____No

Were there complications during pregnancy? _____Yes _____No

If yes, _____Diabetes _____Premature Labor _____Toxemia _____Pre-eclampsia _____Other:_____

Full Term Pregnancy: _____Yes _____No If "No," at how many weeks was your child born?_____

How long did your child remain in the hospital after birth? _____

Any other comments (i.e., jaundice, twin/multiple birth, breathing problems at birth)? _____

_____

Did the child's mother/you experience health problems at/ immediately after your child's birth? _____Yes _____No

If yes, please describe: _____

How much did your child weigh? _____lbs _____oz

Did the child's mother/you use tobacco, alcohol, prescription medications (other than prenatal vitamins) or recreational drugs during pregnancy? _____Y _____N If yes, please explain: _____

_____

<u>Early Developmental Milestones</u>:

Please indicate the age at which your child achieved each milestone. If you are unable to remember approximate ages, please indicate whether your child seemed to achieve these developmental milestones early, on time or late.

Sat without support	**_____**	**early**	**on time**	**late**
Crawled	**_____**	**early**	**on time**	**late**
Stood alone	**_____**	**early**	**on time**	**late**
Said 2 words other than mama/dada	**_____**	**early**	**on time**	**late**
Walked alone	**_____**	**early**	**on time**	**late**
Spoke in sentences	**_____**	**early**	**on time**	**late**

Potty trained _____ early on time late

Please describe any other milestones that stood out: _____

<u>Social/ Support:</u>

Does your child talk easily with others? _____Yes _____No

Does your child make friends easily? _____Yes _____No

Is your child sexually active? _____Yes _____No

How does your child describe his/ her sexual orientation? _____

How does your child describe his/ her gender identity? _____

Does your child have supportive relationships? _____Parents _____Guardians _____Siblings _____Close Friends _____Boyfriend/Girlfriend _____Extended Family _____Faith/Religious Community _____Other:_____

Does your child have a spiritual/ religious affiliation? _____Yes _____No

If yes, please describe: _____

<u>Educational</u>:

Current grade in school: _____ School: _____ District: _____

Ever repeated a grade? _____Yes_____No If yes, which one(s)? _____ Current Grades: _____

_____Regular Classes _____Special Education Classes _____GT/TAG/Honors _____Alternative Placement

Has your child ever been diagnosed with a learning disability? _____Yes _____No If yes, please describe: _____

_____

Has your child ever participated in speech/ language or occupational therapy? _____ Yes _____No

If yes, please describe: _____

Does your child receive 504 services? _____Yes _____No Does your child have any IEPs? _____Yes _____No

<u>Eating Habits</u>: Is your child a picky eater? _____Yes _____No Any unusual eating habits? _____Yes _____No

If yes, please describe: _____

Number of meals/ day? _____ Have you ever been concerned about your child's eating? _____Yes _____No

If yes, please describe: _____

How many hours/ day does your child engage in exercise/ physical activity? _____

How many hours/ day does your child use electronics (phone, computer/tablet, TV, social media, etc.)? _____

<u>Sleeping</u>: How many hours/ night does your child sleep? _____ How long does it take your child to fall asleep? _____

Does your child have nightmares? _____Yes _____No If yes, how often does this occur? _____

Does your child have night terrors? _____Yes _____No **If yes, how often does this occur? _____**

Does your child wet the bed? _____Yes _____No **If yes, how often does this occur? _____**

Does your child walk in his/ her sleep? _____Yes _____No **If yes, how often does this occur?_____**

Any other sleep problems? _____

Pain: Is your child currently experiencing any pain? _____No _____Yes If yes, explain: _____

If yes, what is his/ her current level of pain from 0-10 (10 being worst)? _____

Has your child had any pain during the past 2 months _____No _____Yes If yes, explain: _____

Medical Review of Systems

Please circle any problems your child is experiencing.

Eyes, Ears, Nose & Mouth _____no problems
Glaucoma
Teeth problems
Visual loss
Double vision
Red/pink eye
Hearing loss
Discharge from ears
Nasal obstruction
Discharge from nose/nose bleeds
Head or throat pain
Other:_____

Endocrine/Skin _____no problems
Increased sweating
Can't tolerate cold/ heat
Extreme fatigue
Night sweats
Weight loss/ gain
Increased thirst/ dry mouth
Increased appetite
Increased urination
Bruising or scaling of skin
Rash and/or itching skin
Other:_____

Cardiovascular _____no problems
Structural defects/ abnormalities:_____
Heart skips a beat/arrhythmia
History of heart murmurs

Gastrointestinal _____no problems
Stomachaches
Nausea
Vomiting
Acid Reflux Disease
Constipation or Diarrhea
Abdominal pain
Blood in stools
Black stools
Loss of bowel control
Other:_____

Genitourinary _____no problems
Kidney problems/pain/stones
Jaundice (yellow skin)
Bladder infection
Painful urination
Blood in urine
Frequent nighttime urination
Nighttime incontinence (bed wetting)
Daytime incontinence
Sexually transmitted diseases (STDs)
Irregular Periods (if applicable)
Other:_____

Neurological _____no problems
Dizziness
Headaches
Migraines

Increased heart rate
Slowed heart rate
Chest pain
Swelling of feet
Episode of fear/ panic
Other:_____

Blacking out/ passing out/ seizures
Loss of sensations/ tremors/ tics
Speech problems
Sleep problems
Walking problems
Numbness/ tingling
Other:_____

<u>Respiratory</u> _____no problems
Shortness of breath/ Asthma/ Reactive Airway Disease
Wheezing
Pneumonia
Chronic cough
Coughing up blood
Other:_____

<u>Musculoskeletal</u> _____no problems
Fractured bones
Painful joints
Stiff or swollen joints
Night cramps
Muscle weakness
Restricted motion
Other:_____

Does your child engage in any self-injurious behavior (e.g. cutting, burning, biting, hitting, scratching)? Describe:
_____

Who is your child's current primary care physician? _____

Does your child have a current psychiatrist? _____ If yes, please provide name: _____

When was your child's last physical exam? _____ Last dental exam? _____

Last hearing test? _____ Last vision test? _____

Has your child ever had an elevated lead level? _____Yes _____No

Has your child ever had the following tests? EEG (Brain wave test) _____Yes _____No

CAT scan (Brain scan) _____Yes _____No EKG (heart test) _____Yes _____No

Neurological Evaluation _____No _____Yes If yes, please describe:_____

Does your child have a history of head trauma? _____No _____Yes If yes, please explain: _____

_____

At what age? _____ Was there a loss of consciousness? _____Yes _____No

Medical hospitalizations? _____Yes _____No If yes, list reason and year: _____

_____

Surgeries/ Operations? _____Yes _____No If yes, list reason and year: _____

_____

Has your child been diagnosed with a chronic medical condition? _____Yes_____No If yes, please describe: _____

_____

Immunizations Current? _____Yes _____No

<u>Family Medical / Psychiatric History</u>:

Have members of the child's immediate or extended family ever had the following conditions? If so, please circle the condition and indicate which family member.

Heart problems_____ **Migraines_____**

Seizures_____ **Thyroid_____**

Multiple Sclerosis_____ **High Blood Pressure_____**

Diabetes_____ **Lung Problems_____**

Stomach Problems_____ **Arthritis_____**

Cancer_____ **Kidney Problems_____**

Reading Problems_____ **Other Learning Disabilities_____**

Autism_____ **Intellectual Disability_____**

Speech/ Language Problem_____ **Tuberculosis_____**

Alcohol Abuse/Dependence_____ **Drug Abuse/Dependence_____**

Mental Illness / Emotional/Behavioral/Psychological Problems (Details will be asked during appointment): _____

_____

_____

Please list any other medical concerns: _____

_____

Does your child have any allergies? _____Yes_____No If yes, please list (i.e., specific medications, foods, environmental):_____

Current Prescription Medications: _____

_____

Current Over-the-Counter Medications/Herbs/Supplements: _____

_____

Past Prescription Psychiatric Medications:_____

_____

Has your child had any past psychiatric hospitalizations, residential treatment placements or participated in intensive outpatient programs? _____No_____Yes If yes, please describe: _____

_____

_____

Has your child previously participated in psychotherapy or counseling? _____Yes _____No If yes, please describe:

_____

<u>Legal</u>: History of legal charges? _____No_____Yes (circle: current pending past) For what?_____

History of detention/ probation? _____No_____Yes If yes, where/ when/for what? _____

_____

<u>Alcohol/ Substance Use</u>: Do you know or suspect your child is using/ abusing alcohol, drugs or other substances?

___No___Yes If yes, please explain:
_____

Does your child use tobacco products? _____No_____Yes If yes, please describe:_____

<u>Abuse</u>: Do you know or suspect that your child has been physically or sexually abused? _____No_____Yes If yes, please briefly explain: _____

Has CPS ever been involved? _____No_____Yes If yes, please briefly explain: _____

_____

Has your child witnessed domestic violence? _____No_____Yes If yes, please briefly explain: _____

_____

Has your child ever been the victim of physical, verbal, social or emotional bullying? _____No_____Yes If yes, please briefly explain: _____

<u>Home Safety</u>:

Are there guns in your home? _____Yes_____No If yes, are firearms stored safely (e.g., guns locked, ammunition locked and stored separately, guns unloaded) _____Yes_____No

FOR SAFETY, WHICH OF THE FOLLOWING WOULD YOU BE WILLING TO DO (check all that apply)? __Remove guns from home __Leave guns in home safely stored __Secure and lock sharps (e.g., knives, razors, axes, saws, other tools, etc….) __Secure and lock all over-the counter and prescription medications