Development Centers
Inspiring Hope...Improving Lives

CHILDRENS HEALTH HISTORY

Name: _____ **Date:** _____ **DCI#:** _____

Address: _____ **City, State, Zip** _____ **Phone:** _____

1. GENERAL HEALTH

A. Date of last physical exam or office visit: _____ Age: _____ Weight: _____
Name and Address of PCP: _____

B. Is your child seeing a doctor for any health concerns at this time? ☐ No ☐ Yes, If yes, please identify:

_____

_____

_____

C. Does your child have a dentist? ☐ No ☐ Yes Date of Last visit to Dentist: _____

D. Has your child had an eye exam? ☐ No ☐ Yes Date of Last Eye Exam: _____

E. LIVING HABITS. Any problems or recent changes (indicate change/problem and frequency of occurrence)

	Yes	No	Unkn	Comments
Appetite	☐	☐	☐	
Sleep	☐	☐	☐	
Sexuality	☐	☐	☐	
Weight	☐	☐	☐	
Increase				
Loss	☐	☐	☐	
	☐	☐	☐	
Use of				
Alcohol(quantity)				
Cigarettes(quantity)	☐	☐	☐	
Drugs(quantity/frequency)	☐	☐	☐	
	☐	☐	☐	
History of alcohol or drug dependency services	☐	☐	☐	

2. MEDICATION: A. Prescription and non-prescription drugs taken currently and for the past six months

Medication	**Dosage**	**Prescribing Dr. Name**	**How long have you been taking?**	**Purpose**

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List medications you have tried that did not work, gave you side effects, unpleasant reactions?

Medication	**Taken for**	**why you won't take it again?**

3. ALLERGIES: ☐ YES ☐ NO If yes, describe: _____

_____

4. HEALTH ISSUES:

Is your child currently experiencing pain? ☐YES ☐ NO If yes, please describe: _____

_____

Have you or your child been in contact with anyone with a communicable disease (vomiting, jaundice, rash, chickenpox, measles, productive cough) in the last 8 weeks? ☐ YES ☐NO

If yes, please describe:

_____

_____

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HEALTH ISSUE	YES	NO	COMMENT
Accident Prone	☐	☐	
AIDS	☐	☐	
Anemia	☐	☐	
Asthma	☐	☐	
Breathing/Upper Respiratory Infections	☐	☐	
Cancer	☐	☐	
Chest Pain	☐	☐	
Chicken Pox	☐	☐	
Colitis	☐	☐	
Diabetes (High Blood Sugar)	☐	☐	
Diarrhea/Constipation	☐	☐	
Ears	☐	☐	
Enuresis (Bed Wetting)	☐	☐	
Epilepsy/Seizures	☐	☐	
Eyes	☐	☐	
Fainting Spells	☐	☐	
GERD	☐	☐	
Headaches	☐	☐	
Heart Problems	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
High Fevers	☐	☐	
HIV/AIDS	☐	☐	
Hospitalization	☐	☐	
Hyperactivity	☐	☐	
Laryngitis (Nose/Throat Problems)	☐	☐	
Lead Exposure	☐	☐	
Lead Levels Checked	☐	☐	
Measles	☐	☐	
Memory Loss	☐	☐	
Mumps	☐	☐	
Pneumonia	☐	☐	
Sickle Cell	☐	☐	
Sinuses	☐	☐	
Skin Disorder (Rashes, Unusual Bruising, Skin Discolorations, etc.)	☐	☐	
Slow Weight Gain/Failure to thrive	☐	☐	
Stomach Disturbance	☐	☐	
Teeth/Gums	☐	☐	
Thyroid	☐	☐	
Weight Problems (Over/Underweight)	☐	☐	

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5. FAMILY HISTORY: If yes, list family member and dates (i.e. maternal grandmother, paternal grandmother)

	Yes	No	Date	Relationship
Tuberculosis	☐	☐	_____	_____
Diabetes	☐	☐	_____	_____
Cancer	☐	☐	_____	_____
Heart Problems	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	_____
Epilepsy/Seizures	☐	☐	_____	_____
Sickle Cell	☐	☐	_____	_____
Hepatitis	☐	☐	_____	_____
Mental Health	☐	☐	_____	_____
Suicide	☐	☐	_____	_____
Substance Use	☐	☐	_____	_____

Other_____

6. SURGERY
Has child your had surgery in the last 5 years? ☐ No ☐Yes If yes, list year and surgery _____

_____

7. SEXUAL HISTORY: Is your child sexually active? ☐ Yes ☐ No ☐ Not Sure If yes, is birth control/safe sex practiced? ☐ Yes ☐ No If yes, check all that are used:

☐ The Pill ☐ I.U.D. ☐ Diaphragm ☐ Condom ☐ Rhythm ☐ None

☐Other: _____

Comments: _____

8. DEVELOPMENTAL: Check the word that best describes your pregnancy with the child who is coming to the clinic:

☐ **Easy** ☐ **"Normal"** ☐ **Difficult** **Explain:** _____

_____

9. How many pounds did you gain during this pregnancy? _____ Was this a full-term pregnancy? ☐ Yes ☐ No

How long was the labor? _____ Briefly describe your labor:_____

10. Did you have any difficulties (physical or emotional) following the birth of this child? ☐Yes ☐ No

Comments: _____

11. Check the word that describes your child as a newborn/infant: ☐ Easy ☐ Normal ☐ Difficult

Comments: _____

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12. Did your child experience any of the following in early infancy? ☐ Premature ☐ Failure to Thrive ☐ Jaundice ☐ Vomiting ☐ Colic ☐ High Fevers ☐ Wright Loss ☐ Poor Sleep ☐ Allergies ☐ Seizures ☐ Lead Poisoning ☐ Surgery ☐ Accidents ☐ Other:_____

_____

13. Has your child had all the required shots (immunizations) for their age? ☐ Yes ☐ No Comments:_____

_____

14. Your child's development:

a. At what age did your child: Stop Breast Feeding _____ Stop taking the bottle _____ Smile or Coo_____ Reach for objects_____ Sit alone _____ Crawl_____ Walk_____ Talk in Sentences_____ Toilet Train _____ Tied Shoes_____ Learned to write name_____

b. In your opinion, did your child learn these new skills: ☐ The same as other children ☐ Slower than other children ☐ Faster than other children ☐ Never compared/noticed ☐ Teacher/Day Care Provider has expressed concerns

Do you have any concerns about your child's development?_____

15. Any other health problems or areas of concern with this child? ☐ Yes ☐ No Comments:_____

_____

16. How do you evaluate this child's health today? ☐ Good ☐ Fair ☐ Poor Comments:_____

_____

17. ***I understand and I have received the flyer explaining that as a Medicaid recipient, my child is entitled to the EPSDT screening and medical check-ups by our Primary Care Physician. I understand that my therapist here at Development Centers should be sent a copy of my child's completed EPSDT.***

☐ ***Yes*** ☐ ***No***

Health History Completed by: _____ _____

Consumer/Guardian Signature **Date**

RECOMMENDATIONS BY DC PYCHIATRIST OR NURSE: (Check ONE of the following)

☐ Based on a review of this Assessment, a physical examination is required.

☐ Based on a review of this Assessment, a physical examination is NOT required.

☐ Based on a review of this Assessment, a physical examination is not required BUT follow-up is recommended because _____

Health History Reviewed by: _____ _____

DC Psychiatrist or Nurse **Date**