# Chattahoochee Child Psychology, LLC

## Health History Information

**Client Number** (office use)**:** _____________________

**Client's Name:** __________________________________ **Date:** ____/____/____

**Gender:** ☐ Female ☐ Male **Client's Date of Birth:** ____/____/_____ **Age:** ______

**Respondent's Name:** ____________________________ **Relationship to Client:** ___________________

**Family Health History:**

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

☐Allergies
☐Anemia
☐Asthma
☐Bleeding tendency
☐Blindness
☐Cancer
☐Cerebral Palsy
☐Cleft lips
☐Cleft palate
☐Deafness
☐Diabetes
☐Glandular Problems
☐Heart Disease
☐High blood pressure
☐Kidney disease
☐Mental Illness
☐Migraines
☐Multiple sclerosis
☐Muscular Dystrophy
☐Nervousness
☐Perceptual motor disorder
☐Mental retardation
☐Seizures
☐Spinal Bifida
☐Suicide
☐Other (specify): _________
_________________________

Comments: ______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Clients' Health Examinations/Medications:**

Date of most recent physical examination**:** _______/_______/_______

Date of most recent dental examination**:** _______/_______/_______

Date of most recent vision examination**:** _______/_______/_______

Date of most recent hearing examination**:** _______/_______/_______

Are client's immunizations up-to-date? ☐Yes ☐No ☐Don't Know

**Client's Health History:**

Has the client ever experienced any of the following illnesses/health conditions? Check those which apply and indicate whether they are a past or current problem for the client:

| Condition | Past | Current | Condition | Past | Current |
|---|---|---|---|---|---|
| ☐ Abortion | ☐ | ☐ | ☐ Meningitis | ☐ | ☐ |
| ☐ Asthma | ☐ | ☐ | ☐ Miscarriage | ☐ | ☐ |
| ☐ Blackouts | ☐ | ☐ | ☐ Multiple Sclerosis | ☐ | ☐ |
| ☐ Bronchitis | ☐ | ☐ | ☐ Mumps | ☐ | ☐ |
| ☐ Cerebral Palsy | ☐ | ☐ | ☐ Muscular Dystrophy | ☐ | ☐ |
| ☐ Chicken Pox | ☐ | ☐ | ☐ Nose bleeds | ☐ | ☐ |
| ☐ Congenital problems | ☐ | ☐ | ☐ Other skin rashes | ☐ | ☐ |
| ☐ Croup | ☐ | ☐ | ☐ Paralysis | ☐ | ☐ |
| ☐ Deafness | ☐ | ☐ | ☐ Pleurisy | ☐ | ☐ |
| ☐ Diabetes | ☐ | ☐ | ☐ Pneumonia | ☐ | ☐ |
| ☐ Diphtheria | ☐ | ☐ | ☐ Polio | ☐ | ☐ |
| ☐ Dizziness | ☐ | ☐ | ☐ Pregnancy | ☐ | ☐ |
| ☐ Ear aches | ☐ | ☐ | ☐ Rheumatic Fever | ☐ | ☐ |
| ☐ Ear infections | ☐ | ☐ | ☐ Scarlet Fever | ☐ | ☐ |
| ☐ Eczema | ☐ | ☐ | ☐ Seizures | ☐ | ☐ |
| ☐ Encephalitis | ☐ | ☐ | ☐ Severe Head Injury | ☐ | ☐ |
| ☐ Fevers | ☐ | ☐ | ☐ STD | ☐ | ☐ |
| ☐ Hayfever | ☐ | ☐ | ☐ Thyroid Disorder | ☐ | ☐ |
| ☐ Hearing Problems | ☐ | ☐ | ☐ Vision Problems | ☐ | ☐ |
| ☐ Heart trouble | ☐ | ☐ | ☐ Wears Glasses | ☐ | ☐ |
| ☐ Hepatitis | ☐ | ☐ | ☐ Whooping Cough | ☐ | ☐ |
| ☐ Hives | ☐ | ☐ | ☐ Other | ☐ | ☐ |
| ☐ Influenza | ☐ | ☐ | Specify: ______________________ | | |
| ☐ Lead Poisoning | ☐ | ☐ | ______________________ | | |

List any recent health or physical changes: ________________________________________

________________________________________________________________________

**Nutrition:**

| Meal | How often (times per week) | Typical foods eaten | Typical amount eaten |
|---|---|---|---|
| Breakfast | _____/ week | ______________________ | ☐ No ☐ Low ☐ Med ☐ High |
| Lunch | _____/ week | ______________________ | ☐ No ☐ Low ☐ Med ☐ High |
| Dinner | _____/ week | ______________________ | ☐ No ☐ Low ☐ Med ☐ High |
| Snacks | _____/ week | ______________________ | ☐ No ☐ Low ☐ Med ☐ High |

Comments: ________________________________________________________________

________________________________________________________________________

Any recent changes in appetite? ☐ No ☐ Yes, describe: ______________________________

________________________________________________________________________

**Medications:**

| Current prescribed medications | Dose | Date Began | Purpose | Side effects |
|---|---|---|---|---|
| ☐ None | | | | |
| | | | | |
| | | | | |
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| | | | | |

| Current over-the-counter meds | Dose | Date Began | Purpose | Side effects |
|---|---|---|---|---|
| ☐ None | | | | |
| | | | | |
| | | | | |
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| | | | | |

| Past psychotropic medications | Dose | Date Start/End | Purpose | Side effects |
|---|---|---|---|---|
| ☐ None | | | | |
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## For Staff Use

Psychologist's comments: ____________________________________________________________

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____________________________________________________________

Physical exam recommended: ☐ Yes ☐ No/NA Dental exam recommended: ☐ Yes ☐ No/NA

Psychologist's signature/credentials: ________________________________________

Date: _____/_____/______