Chattahoochee Child Psychology, LLC

Health History Information

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

Gender: ☐F ☐M ☐ Non-Binary ☐ Transgender Female ☐ Transgender Male ☐ Other

Client's Date of Birth: ____/____/____ **Age:** _____ **Race/Ethnicity:** _____

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:

	Past	Current		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				

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

Past psychotropic medications	Dose	Date Start/End	Purpose	Side effects
☐ None				

For Staff Use

Provider's comments: _____

_____

_____

_____

_____

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

Provider's signature/credentials: _____

Date: _____/_____/_____