MODIFY

Child Medical History

Date: _____

Patient Name: _____ DOB: _____

Age: _____ Gender Identity: _____ Pronouns: _____ Height: _____ Weight: _____

Preferred Name: _____

Person Completing Questionnaire: _____Relationship to Patient: _____

1. ***General Medical Information:***

   a. *What brings your child to counseling? _____*

   _____

   b. *What symptoms has your child been experiencing? _____*

   _____

   c. *Have you noticed a change in your child's general health within the last year? Yes____ No____*

      If yes, please describe: _____

      _____

   d. *Date of your child's last physical examination? _____*

   e. *Name and phone number of your child's primary care physician?*

      _____

   f. *Has your child had any serious illnesses, operations, medical or psychiatric hospitalizations? Yes ___ No___*

      If yes, please describe: _____

      _____

   g. *Has your child been seen by a neurologist? Yes _____No _____ If so, for what reason? _____*

      _____

      _____

2. ***Medications:***

Please list any current medications or supplements your child is currently taking, along with the reason:

_____

_____

_____

Is your child allergic to any medications? Yes _____No _____ If so, please list them below:

_____

_____

3. Past Medical History:

Has your child had any of the following medical procedures:

CT scan (head)	*Yes_____*	*No _____*	*Age_____*
MRI scan (head)	*Yes _____*	*No _____*	*Age _____*
EEG (head)	*Yes _____*	*No _____*	*Age _____*
EKG (heart)	*Yes _____*	*No _____*	*Age _____*

Has your child had any of the following medical conditions and, if so, at what age?

High Fevers	*Yes _____*	*No _____*	*Age_____*
Ear Infections	*Yes _____*	*No _____*	*Age _____*
Head Trauma	*Yes _____*	*No _____*	*Age _____*
Loss of Consciousness	*Yes _____*	*No _____*	*Age _____*
Seizures	*Yes _____*	*No _____*	*Age _____*
Obesity	*Yes _____*	*No _____*	*Age _____*
Headaches	*Yes _____*	*No _____*	*Age _____*
Broken Bones	*Yes _____*	*No _____*	*Age _____*
Heart Problems	*Yes _____*	*No _____*	*Age _____*
Lung Problems	*Yes _____*	*No _____*	*Age _____*
Bowel Problems	*Yes _____*	*No _____*	*Age _____*
Stomach Problems	*Yes _____*	*No _____*	*Age _____*
Urinary Problems	*Yes _____*	*No _____*	*Age _____*
Allergies	*Yes _____*	*No _____*	*Age _____*
Asthma	*Yes _____*	*No _____*	*Age _____*
Hearing Problems	*Yes _____*	*No _____*	*Age _____*
Eye Problems	*Yes _____*	*No _____*	*Age _____*
Surgeries	*Yes _____*	*No _____*	*Age _____*
Diabetes	*Yes_____*	*No_____*	*Age_____*
Cancer	*Yes_____*	*No_____*	*Age_____*
Chronic Pain	*Yes_____*	*No_____*	*Age_____*

If you answered yes to any of the above, please specify: _____

_____

_____

Does your child currently experience any of the following?

Difficulty with concentration	*Yes _____*	*No _____*	*Isolation from others*	*Yes _____*	*No_____*
Hyperactivity	*Yes _____*	*No _____*	*Low Self-Esteem*	*Yes _____*	*No_____*

Low Motivation	*Yes _____*	*No _____*	*Tearful/Crying spells*	*Yes_____*	*No_____*
Fatigue/Low Energy	*Yes _____*	*No _____*	*Hopelessness*	*Yes_____*	*No_____*
Increased Appetite	*Yes _____*	*No _____*	*Excessive gaming*	*Yes_____*	*No_____*
Decreased Appetite	*Yes _____*	*No _____*	*Excessive Social Media*	*Yes_____*	*No_____*

Do you believe that your child uses any of the following: (check all that apply)

Recreational Drugs	*Yes _____*	*No _____*
Alcoholic Beverages	*Yes _____*	*No _____*
Caffeinated Drinks	*Yes _____*	*No _____*
Smoking or Vaping	*Yes _____*	*No _____*

If you checked yes to any of the above, please describe:

_____

_____

4. Family Topics:

Is there a history of mental illness in your family? If yes, please describe the illness and relationship to the child:

_____

_____

_____

Are there any spiritual/cultural factors you would like us to be aware of during your child's care?

_____

Is there a parental agreement in place for your child that we would need to be aware of? If so, please explain:

_____

_____

_____

Does your child have any resources being utilized in their school? (504 plan, IEP, etc.)

_____

_____

What are you hoping you child will gain from counseling? _____

_____