MODIFY

Child Medical History

Patient Name: _____ DOB: _____ Date: _____

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

Preferred Name: _____

Person Completing Questionnaire: _____Relationship to Patient: _____

1. General 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. Has your child had any serious illnesses, operations, medical or psychiatric hospitalizations? Yes _____ No_____

If yes, please describe: _____

_____

e. 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:

_____

_____

Please list any allergies to medications: _____

_____

3. Past Medical History

Has your child had any of the following medical procedures:

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

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

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

If you answered yes to any of the above, please specify and list age medical condition started _____

_____

_____

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:

_____

_____