

CONFIDENTIAL MEDICAL HISTORY

Tahoe Youth & Family Services CLIENT (CHILD 0-9 Years)

To be filled out by the parent/guardian. Our Medical Director will review this form.

Today's Date: ____ / ____ / ____

Client #: _____

Name: _____

Sex: M F Age: _____

Date of Birth: ____ / ____ / ____

Place of Birth: _____

Current State of Child's Health: Excellent Good Fair Poor

Was child premature? Yes No How many weeks? _____

Please check below any health problems your child has or has had, past or present.

Nervousness/Anxiety Insomnia Depression

Please indicate any psychiatric/psychological treatment:

None

Outpatient (Date: ____ / ____ / ____) Where: _____

Inpatient (Date: ____ / ____ / ____) Where: _____

Please list any hospitalizations (including psychiatric):

AGE	ILLNESS/INJURY/OPERATION	OUTCOME
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had any suicide attempts? Yes No

Any attempts without hospitalization? Yes No

If "yes", please explain: _____

Has your child ever had problems with eating or weight, such as bulimia, anorexia, over-eating, or not eating? Yes No

Has your child had any history of cutting or self-mutilation? Yes No

Has your child been molested or assaulted? Yes No

Were they treated by a physician? Yes No

If "yes", when? _____ / _____ / _____

Please check any past or current health problems below. If none, leave blank.

PROBLEM/SYMPTOM	AGE	P=PAST/ C=CURRENT	PROBLEM/SYMPTOM	AGE	P=PAST/ C=CURRENT
Tonsils out	_____	_____	Dental Problems	_____	_____
Allergies/Asthma	_____	_____	Eating Disorders	_____	_____
Emphysema	_____	_____	Frequent Headaches	_____	_____
Bronchitis	_____	_____	Depression/Suicidal Thoughts	_____	_____
Pneumonia	_____	_____	Excessive Fatigue	_____	_____
Tuberculosis	_____	_____	Persistent Diarrhea (for weeks or months)	_____	_____
Anemia	_____	_____	Kidney/Bladder Trouble	_____	_____
Blood Clotting	_____	_____	Polio	_____	_____
High Blood Pressure	_____	_____	Rheumatic Fever	_____	_____
Heart Trouble	_____	_____	Malaria	_____	_____
Diabetes	_____	_____	Mononucleosis	_____	_____
Cancer or Tumor	_____	_____	Encephalitis	_____	_____
Epilepsy	_____	_____	Meningitis	_____	_____
Yellow Jaundice	_____	_____	Skin Problems	_____	_____
Ulcers	_____	_____	Persistent White Spots or Blemishes in the Mouth	_____	_____
Arthritis/Gout	_____	_____	Unexplained Excessive Weight Loss	_____	_____
Thyroid Disease	_____	_____	Hyperactivity	_____	_____
Liver Disease	_____	_____	Accident Prone	_____	_____
Chicken Pox	_____	_____	Head Injuries	_____	_____
Measles	_____	_____			
Mumps	_____	_____			
Ear aches	_____	_____			
Vision Problems	_____	_____			
Hearing Problems	_____	_____			

Other: _____

Please give details on any "yes" responses: _____

Is your child currently taking any medications? If "yes", please list:

MEDICATION

TAKEN FOR

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has your child ever taken any medications for moods (depression, anxiety) or behavior (hyperactivity), such as Paxil, Prozac, Zoloft, Ritalin, etc.? Yes No Not Sure

If "yes", please list: _____

Is anyone in your immediate family taking any of these medications? Yes No

If "yes", who, and what is s/he taking? _____

How many caffeinated beverages (sodas, coffee, tea, iced tea) does your child drink per day? _____

Are your child's immunizations (vaccines) up to date? Yes No

Date of last tetanus shot: _____ / _____ / _____

Does your child have any current medical problems that may interfere with his/her participation in counseling? Yes No

If "yes", please explain: _____

Does your child have medical insurance? Yes No If "yes", who is your carrier? _____

If "no", is your child on Medi-Cal? Yes No

Please provide copy of Medi-Cal card and #: _____ Social Security #: _____

Where does your child obtain medical services? Health Department Private Physician

Who is your child's doctor? _____

SECTION TO BE COMPLETED BY MEDICAL DIRECTOR

Physical Exam Waived

Physical Exam Recommended

Doctor's Signature

____ / ____ / ____
Date

Doctor's Comments: _____

