Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

	Name	Address	Phone/email
Legal guardian:	Mother : Father: Appointed Guardian:		

Health Care Providers	**Name**	**Address**	**Phone/ email**
Referring source:			
Primary Care Provider:			
Psychiatric Provider:			
Therapist:			
In Home skills worker:			
Social Worker:			
Other medical providers:			

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates: Provide copy of all immunizations (birth to current age)	☐ TDap (Tetanus) most recent	☐ Pneumonia (most recent)
		☐ Chickenpox
	☐ Influenza (most recent)	☐ MMR *Measles, Mumps, Rubella*

Check previous/ ongoing medical concerns (resident)

Treatment recommended

Asthma ☐_____
Acne ☐ _____
Heart condition ☐_____
Anemia (low iron) ☐_____
Migraines ☐_____
High BP ☐ _____

Overweight ☐_____
Encopresis ☐_____
Enuresis (bedwetting) ☐_____
Constipation ☐ _____
Eczema ☐_____
Tics/Tourette's ☐_____
Seizure ☐_____
Diabetes ☐_____
Physical disability☐_____
Food Intolerance ☐_____
Scoliosis ☐ _____
Other_____

Injuries – Fractures -
Head injuries – yes_____ no_____ Number_____
Concussion- yes _____ no_____ Number_____

Surgeries		
Year	Reason	Hospital

Hospitalizations (Medical and Mental Health)		
Date/Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications/ food/ environmental	
Name	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY (CHILD/ ADOLESCENT)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Weight gain (last 6 months)				☐ Yes	☐ No
	Weight loss (last 6 months)				☐ Yes	☐ No
	Treatment for eating disorder If yes – Where _____When_____				☐ Yes	☐ No
	Over eating-binging	☐ 1 -2 times week	☐ 3-4 times weeks	☐ 5 or more times week		
	Purging	☐ 1-2 times week	☐ 3-4 times a week	☐ 5 or more times week		
Caffeine	☐ None	☐ Coffee/tea	☐ energy drinks	☐ Pop/Soda		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How often-					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Other	☐	
	☐ # of months	☐ Last time use tobacco				
Drugs	Do you currently use recreational or street drugs? List what used (OTC, Rx medications, Meth.,Cocaine, Marijuana ect)				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	Ever had unwanted sex (raped/sexually abused)				☐ Yes	☐ No
	Are you currently on contraceptive (BCP, Implant, Nuvaring, Depo provera, IUD)					
					☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Have you ever been bully or teased?				☐ Yes	☐ No
	Do you feel safe in current living situation?				☐ Yes	☐ No
	Have you ever been physically hurt by someone?				☐ Yes	☐ No
	Do you have access to guns in your current living situation?				☐ Yes	☐ No
	Is there physical and verbal aggression in current living situation?				☐ Yes	☐ No
	Have you lived out of the home in last 12 months, if yes how many different places					

	Foster Home_____Group Home_____Residential_____other_____	☐ Yes	☐ No
MENTAL HEALTH (CHILD/ ADOLESCENT FILLS OUT)			
Is stress a major problem for you?		☐ Yes	☐ No
Do you feel depressed?		☐ Yes	☐ No
Do you panic when stressed?		☐ Yes	☐ No
Do you have problems with eating or your appetite?		☐ Yes	☐ No
Do you cry frequently?		☐ Yes	☐ No
Have you ever attempted suicide?		☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?		☐ Yes	☐ No
Have you ever hurt self on purpose (cutting, scratching, suicide attempt) **If yes last time** _____		☐ Yes	☐ No
Parent/ Guardian Fill out: Previous mental health Diagnosis (please list)_____ Previous medication tried for Mental Health concerns (please list)_____		☐ Yes	☐ No

FAMILY HEALTH HISTORY (MOTHER, FATHER, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES) PLEASE CHECK			
Depression	Asthma	Cancer	HIV
Anxiety Autistic Spectrum disorder (Aspergers, PDD, Autism)	Allergies	Type-	Hep B
ADHD	Immune disorder		Hep C
Bipolar	Eczema	Heart Condition	Fetal Alcohol syndrome
Schizophrenia	Enuresis (bedwetting)	High BP	Chemical Abuse
Genetic disorder	Encopresis (soiling pants)	High Cholesterol/Trigs	Migraines
Borderline IQ	anemia	Overweight	Seizures
Learning Disorders	Hearing loss	Constipation	Tuberculosis
Other health concerns in family members-			

I verify that Information provided on this form is accurate to the best of my knowledge. This information will be keep confidential and use for purpose of better serve your child medical and mental health needs through Greater MN family services.

Parent/guardian Date

Relationship to resident