Key Point
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS

Client Name: _____ **Client DOB:** _____

CHILD/ADOLESCENT HEATLH HISTORY - MEDICAL

Please explain any selected response(s) on the lines following the selection.

Eyes, Ears, Nose, Throat

- ☐ None Reported
- ☐ Eye/Vision Problems
- ☐ Nose Problems/Nosebleeds
- ☐ Glaucoma
- ☐ Throat Problems
- ☐ Ear/Hearing Problems
- ☐ Other

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Musculoskeletal

- ☐ None Reported
- ☐ Arthritis
- ☐ Gout
- ☐ Bone/Joint Difficulty
- ☐ Other
- ☐ Back Pain/Injuries

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Blood/Lymphatic System

- ☐ None Reported
- ☐ Anemia (Low RBC Count)
- ☐ Other
- ☐ Bleed Easily
- ☐ Bruise Easily

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Circulatory/Cardiac Systems

- ☐ None Reported
- ☐ Coronary Artery Disease
- ☐ Angina
- ☐ Rheumatic Fever
- ☐ Other
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Abnormal EKG
- ☐ Irregular Heart Beat
- ☐ Chest Pain
- ☐ Heart Attack

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Endocrine System

- ☐ None Reported
- ☐ Diabetes
- ☐ Excessive Urination
- ☐ Menopause
- ☐ Other
- ☐ Thyroid Disease
- ☐ Weight Gain
- ☐ Menopause Problems
- ☐ Excessive Thirst
- ☐ Weight Loss
- ☐ Erectile Dysfunction

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Gastrointestinal System

- ☐ None Reported
- ☐ Difficulty Swallowing
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis A
- ☐ Hemorrhoids/Rectal Disease
- ☐ Vomiting
- ☐ Diverticulosis
- ☐ Liver
- ☐ Ulcer
- ☐ Hepatitis B
- ☐ Reflux
- ☐ Diarrhea
- ☐ Stomach Pain
- ☐ Jaundice
- ☐ Constipation
- ☐ Hepatitis C
- ☐ Nausea
- ☐ Other

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Genital/Urinary System

- ☐ None Reported
- ☐ Urinary Tract Problems
- ☐ Sexual Difficulties
- ☐ Prostate
- ☐ Sexual Transmitted Disease
- ☐ Infections
- ☐ Other

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Nervous System

- ☐ None Reported
- ☐ Seizures/Epilepsy
- ☐ Loss of Coordination
- ☐ Head Injury
- ☐ Black-Outs
- ☐ Headaches
- ☐ Speech Problems
- ☐ Spinal Cord Injury
- ☐ Dizziness
- ☐ Tremors
- ☐ Loss of Feeling in Hand/Foot
- ☐ Sleep Problems
- ☐ Other

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Respiratory System

- ☐ None Reported
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Other
- ☐ Frequent Coughing
- ☐ Asthma
- ☐ Tuberculosis/Results
- ☐ Bronchitis

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Integumentary System

- ☐ None Reported
- ☐ Boils
- ☐ Psoriasis
- ☐ Other
- ☐ Itching
- ☐ Rashes
- ☐ Acne
- ☐ Eczema

_____

_____

Additional Questions

Have you ever had any surgeries? ☐ Yes ☐ No

_____

_____

Have you had cancer? ☐ Yes ☐ No

_____

_____

Any abnormal lab tests/results? ☐ Yes ☐ No

_____

_____

Have you ever had a head injury? ☐ Yes ☐ No
If yes, did you lose consciousness/have a concussion? ☐ Yes ☐ No

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**=For Females Only:*
*Any problems with menstruation? ☐ Yes ☐ No
*Do you plan to become pregnant? ☐ Yes ☐ No
*Do you use birth control? ☐ Yes ☐ No
*Any history of pregnancy, miscarriage or terminations? ☐ Yes ☐ No

CHILD/ADOLESCENT HEALTH HISTORY - FAMILY

If yes, please explain on the lines following selection (family member, health/psychiatric problem)

Has anyone in your family had health problems? ☐ Yes ☐ No

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_____

Has anyone in your family had a psychiatric problem? ☐ Yes ☐ No

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_____

Has anyone in your family had substance-abuse problems? ☐ Yes ☐ No

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CHILD/ADOLESCENT HEALTH HISTORY - PAIN

If yes to either, please explain (on a scale of 1 to 10, 1=lowest, 10=highest, what is your score?)

Are you experiencing any pain right now? ☐ Yes ☐ No

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_____

Do you experience any chronic untreated pain? ☐ Yes ☐ No

_____

_____

CHILD/ADOLESCENT HEALTH HISTORY - DEVELOPMENTAL HISTORY

Birth Father's Information: ☐ Unknown
First Name: _____ Last Name: _____ Age at Birth: ____

Birth Mother's Information: ☐ Unknown
First Name: _____ Last Name: _____ Age at Birth: ____

Biological/Birth Parent's Marital Status (at birth and current): ☐ Unknown

_____
_____

Birth Certificate Information (parents identified on birth certificate): ☐ Unknown

_____
_____

Location of Birth (name of center/facility, home-birth): ☐ Unknown

_____

Place of Birth (city, state, province, county): ☐ Unknown

_____

Pregnancy

Was this a planned pregnancy? ☐ Yes ☐ No ☐ Uncertain
Was this a wanted pregnancy? ☐ Yes ☐ No ☐ Uncertain
Was prenatal medical care provided? ☐ Yes ☐ No ☐ Uncertain
Were there health problems/illness during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were there medical operations/procedures during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were physical injuries/trauma sustained during pregnancy? ☐ Yes ☐ No ☐ Uncertain
Were there other complications/problems during pregnancy? ☐ Yes ☐ No ☐ Uncertain

Prenatal Exposure (check all that apply)

☐ None Reported
☐ Alcohol
☐ Caffeine
☐ Illicit Drugs
☐ Lead/Mercury
☐ Medications (over-the-counter)
☐ Medications (prescription)
☐ Nicotine
☐ Poisons
☐ Toxic Chemicals
☐ Other Dangerous Substances

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Delivery

Pregnancy Length: _____ Weeks
Birth Size: _____ lbs _____ oz.
Labor Length: _____ Hours
Birth Weight: _____ Inches

Complications/Medical Factors

☐ None Reported
☐ Anesthesia Used
☐ Breathing Problems
☐ Bilirubin Lights
☐ Breeched Birth
☐ Caesarean Delivery
☐ Forceps Used
☐ Other Complications
☐ Induced Labor
☐ Premature Birth (incubator)
☐ Supplemental Oxygen
☐ Other Medical Factors

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_____

Early Achievements/Milestones *(If early or delayed, please explain on the lines following this section)*

Turning over on his/her own	Age achieved: _____ months	☐ Unknown
Sitting up on his/her own	Age achieved: _____ months	☐ Unknown
Crawling	Age achieved: _____ months	☐ Unknown
Standing on his/her own	Age achieved: _____ months	☐ Unknown
Walking on his/her own	Age achieved: _____ months	☐ Unknown
Speaking first work	Age achieved: _____ months	☐ Unknown

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Feeding & Weaning

In infancy/childhood, was the child breast-fed? ☐ Yes ☐ No ☐ Uncertain

In infancy/childhood, was the child bottle-fed? ☐ Yes ☐ No ☐ Uncertain

Complications/difficulties: ☐ Unknown

_____

_____

Other problems in infancy: ☐ Unknown

_____

_____

Self Regulation

When did day-time toilet training occur? _____ Months

When did night-time toilet training occur? _____ Months

After toilet trained, did bed-wetting continue to occur? ☐ Yes ☐ No ☐ Uncertain

If so, when did it stop? _____ Months

After toilet trained, did bed-soiling continue to occur? ☐ Yes ☐ No ☐ Uncertain

If so, when did it stop? _____ Months

Physical Injuries & Significant Stressors *(If "yes" to either, please explain on the lines following this section)*

Has the child experienced significant injuries (head injuries, loss of consciousness, etc.)?

☐ Yes ☐ No ☐ Uncertain

Were there any major changes/stressors during patient's infancy/childhood?

☐ Yes ☐ No ☐ Uncertain

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