UPPER VALLEY OUTPATIENT BEHAVIORAL HEALTH SERVICES

CHILD/ADOLESCENT INITIAL MEDICAL HISTORY

Patient Name:_____ Family Physician:_____

Address:_____ Address:_____

Phone:_____ Phone:_____

Birthdate:_____

CURRENT HEALTH CARE

Child's Height_____ Child's Weight_____ Date of last physical exam_____

Do you want information released to your child's physician? _____Yes _____No

Please list any Specialists involved in your child's healthcare:

Physician Name(s)_____

Specialty _____

Condition your child is being treated for _____

Do you want information released to the Specialist currently treating your child? _____Yes _____No

Please list any Allergies:_____

Medication Allergies: _____

PREGNANCY AND BIRTH CONTROL

Is your child is sexually active? _____Yes _____No Does he/she use birth control? _____Yes _____No

What type of birth control is used?_____

CURRENT AND PAST PROBLEMS OR CONDITIONS

List all current medical conditions_____

_____

Is your child being treated for these conditions? _____Yes _____No

● Is your child currently experiencing and medical symptoms or problems that he or she has not been treated or seen by a physician for? _____ Yes _____No

Please List_____

List any serious health issues that occurred in the past (i.e. surgeries, emergency dept. visits. Please give dates.)

_____

Has your child had any head injuries with loss of consciousness? _____Yes_____No

If Yes, please explain._____

Does your child have a history of seizures?_____Yes_____No

(● If marked "Yes", recommendation for additional health assessment is indicated)

CHILD/ADOLESCENT INITIAL MEDICAL HISTORY

NUTRITIONAL ASSESSMENT

Diet Restrictions? _____Yes _____No

If Yes, please explain._____

Appetite Change?_____Yes_____No

If Yes, please explain._____

- Has your child had a recent, unexplained weight gain or loss in the past 3 months? ___Yes_____No

If Yes, please explain._____

- Has your child had recent nausea/vomiting or diarrhea for more than 3 days? _____Yes_____No

If Yes, please explain._____

History of Anorexia?_____Yes_____No History of Binge Eating?_____Yes_____No

History of Bulemia?_____Yes_____No

If Yes, please explain._____

(● If marked "Yes" indicates moderate to high risk, recommendation for additional physical health assessment is indicated)

PAIN ASSESSEMENT

Does your child have any current or recent pain? _____Yes_____No

If Yes, please explain._____

_____

This form was completed by:_____

Relationship to patient:_____

(PLEASE COMPLETE THE FOLLOWING PAGE REGARDING YOUR CHILD'S CURRENT MEDICATIONS)

CHILD/ADOLESCENT INITIAL MEDICAL HISTORY

INITIAL MEDICATION RECONCILLIATION FORM

(Include over the counter medications)

DRUG	**DOSE**	**FREQ,**	REASON PRESCRIBED	PRESCRIBED BY

**********FOR OFFICE USE ONLY**********

Recommendations or referral made_____

_____

_____

_____No Recommendations Needed

Reviewed by:_____Date:_____