Mary Determan MSW, LLC

5757 W. Oklahoma Ave. #203 Milwaukee, WI 53219-4303

BRIEF HEALTH INFORMATION FOR CHILDREN AND ADOLESCENTS

(Please Print)

Client's Name	Date

THIS CHILD/ADOLESCENT'S HEALTH

In general, how would you describe this child/adolescent's health?	□ Excellent	□ Very good	□ Good	□ Fair	□ Poor
How would you describe the condition of this child/adolescent's teeth?	□ Excellent	□ Very good	□ Good	□ Fair	□ Poor

During the past **12 months**, has this child/adolescent had **frequent** or **chronic** difficulty with any of the following?		
	Yes	No
Breathing or other respiratory problems (such as wheezing or shortness of breath)		
Digesting food, including stomach/intestinal problems, constipation, or diarrhea		
Repeated or chronic physical pain, including headaches or other back or body pain		
Toothaches		
Bleeding gums		
Decayed teeth or cavities		

Has a doctor or other health care provider EVER told you that this child/adolescent has:					
	Yes	No		Yes	No
Allergies (such as food, drug, insect, seasonal, or other?			Frequent or severe headaches, including migraine?		
Asthma?			Epilepsy or Seizure Disorder?		
Autoimmune disease (such as Type 1 Diabetes, Celiac, or Juvenile Idiopathic Arthritis)?			Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?		
Cerebral Palsy?			Heart Murmur/Heart Disease?		
Tourette syndrome?			Anxiety Problems?		
Type 2 Diabetes?			Depression?		
Down syndrome?			Cystic Fibrosis?		
Fetal Alcohol Spectrum Disorder (FASD)?			Cancer?		
Thyroid Disorder?			Kidney/Bladder Disorder?		
Dizziness/Fainting with exercise?			Concussion?		

Has a doctor or other health care provider, or **educator** EVER told you that this child/adolescent has:					
	Yes	No		Yes	No
Behavioral or Conduct Problems?			Auditory Processing Disorder?		
Developmental Delay?			Sensory Integration Disorder?		
Intellectual Disability?			Dyslexia?		
Speech or other language disorder?			Dysgraphia?		
Learning Disability?					

Has a doctor or other health care provider, EVER told you that this child/adolescent has:		
	Yes	No
Autism or Autism Spectrum Disorder (ASD)?		
What type of doctor or other health care provider was the FIRST to tell you that this child/adolescent had Autism, ASD, Asperger's Disorder or PDD?		
• Primary Care Provider		
• School Psychologist/Counselor		
• Other Psychologist (Non School)		
• Psychiatrist		
• Other, specify . . .		
Is this child/adolescent CURRENTLY taking medication for Autism, ASD, Asperger's or PDD?		

Name of Medicine	Dosage	Times per Day

	Yes	No
DURING THE PAST 12 MONTHS did this child/adolescent receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD?		

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Has a doctor or other health care provider, EVER told you that this child/adolescent has:		
	Yes	No
Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder that is ADD or ADHD?		
What type of doctor or other health care provider was the FIRST to tell you that this child/adolescent had ADHD/ADD?		
• Primary Care Provider		
• School Psychologist/Counselor		
• Other Psychologist (Non School)		
• Psychiatrist		
• Other, specify . . .		
Is this child/adolescent CURRENTLY taking medication for ADHD/ADD?		

Name of Medicine	Dosage	Times per Day

	Yes	No
DURING THE PAST **12 MONTHS** did this child/adolescent receive therapy for ADHD/ADD?		

HEALTHCARE SERVICES

	Yes	No
DURING THE PAST **12 MONTHS**, did this child/adolescent see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams or any other kind of medical care?		
Are you concerned about this child/adolescent's weight?		
Has a doctor or other health care provider ever told you that this child/adolescent is overweight?		
DURING THE PAST **12 MONTHS**, did this child/adolescent engage in any of the following?		
• Skipping meals or fasting (Do not include skipping meals or fasting for religious reasons)		
• Having low interest in food		
• Extremely picky eating		
• Binge eating		
• Purging or vomiting after eating		
• Using diet pills, laxatives, or diuretics (water pills) to lose or maintain weight without a doctor's orders		
• Over-exercising		
• Not-eating due to fear of vomiting or choking		
DURING THE PAST **12 MONTHS**, how concerned were you about this child/adolescent engaging in these behaviors?		
□ very much □ somewhat □ not at all		
DURING THE LAST **12 MONTHS**, how concerned was this child/adolescent about their weight, body shape, or body size?		
□ very much □ somewhat □ not at all		

	Yes	No
DURING THE PAST **2 YEARS**, has this child/adolescent seen an eye doctor?		
If yes, what care has this child received from the eye doctor?		
• Received eye examination		
• Prescribed eyeglasses or contact lenses		
• Diagnosis of a vision disorder other than nearsighted, farsighted, or astigmatism		
• Some other care		
DURING THE PAST **12 MONTHS**, did this child/adolescent see a dentist or other oral health care?		
DURING THE PAST **12 MONTHS**, has this child/adolescent received any treatment or counseling from a mental health professional?		
DURING THE PAST **12 MONTHS**, has this child/adolescent taken any medication because of difficulties with their emotions?		

Name of Medicine	Dosage	Times per Day

Doctor/Pediatrician:	Phone:
Psychiatrist:	Phone: