PORTER STARKE SERVICES
Health • Balance • Hope

Medical History – CHILD (age 17 and under)

Directions: You can complete this form now and bring it with you to Porter-Starke Services. **Option A**: Type in your answers on the computer and then print it. **Option B:** Print the form first and then write in your answers. Please print clearly.

Child's Name: _____ Date completed: _____

Date of Birth: _____ Age: _____ Current Grade in School: _____

Current School: _____ School Phone: _____

Father's Name: _____ Mother's Name: _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Child referred by: _____ Therapist: _____Primary Care MD: _____

Child's Personal Medical History

List all current medications, vitamins, additives/supplements your child is taking:

1. _____
2. _____
3. _____

List any allergies your child has:

1. _____
2. _____
3. _____

Please check any current symptoms that your child is experiencing or has experienced:

Hearing
- ☐ Chronic ear infections
- ☐ Surgery or tubes
- ☐ Hearing problem

Vision
- ☐ Eye or vision problems
- ☐ Lazy eye
- ☐ Uses prescription glasses or contacts

Neurological
- ☐ Head trauma
- ☐ Severe headaches
- ☐ Seizures
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Black outs
- ☐ Chronic dizziness
- ☐ Poor coordination

Other
- ☐ Shortness of breath or asthma
- ☐ Digestive problems
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Broken bone(s)
- ☐ Muscle problems
- ☐ Hormone system
- ☐ Sleep issues
- ☐ Appetite issues
- ☐ Other (list) _____

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CLIENT NAME:_____ CLIENT NUMBER: _____

NURSE INITIAL/DATE: _____ /_____ DOCTOR INITIAL/DATE: _____ / _____

If concerned about Autism, please answer the following four questions:

1. Has anyone suggested your child might have a developmental delay: ☐ No ☐ Yes
2. Has anyone suggested your child might be mentally handicapped or retarded? ☐ No ☐ Yes
3. Will your child look at people, talk to them and interact with them the way you would expect? ☐ No ☐ Yes
4. Does your child do any of the following?
   - Body rocking ☐ No ☐ Yes
   - Head banging ☐ No ☐ Yes
   - Hand flapping ☐ No ☐ Yes
   - Toe walking ☐ No ☐ Yes
   - Repetitive nonsense sounds ☐ No ☐ Yes

If your child has problems with social skills answer the following questions:

1. Does your child prefer to play alone or with others? ☐ Alone ☐ Others
2. Does your child have close friends? ☐ No ☐ Yes
3. What are your child's hobbies? _____
4. Does your child seem to feel remorse for doing something wrong? ☐ No ☐ Yes
5. Does your child ever feel guilty even when s/he hasn't done anything terribly wrong? ☐ No ☐ Yes
6. Does your child make negative statements about him/herself? ☐ No ☐ Yes
7. Does your child get along with his/her siblings? ☐ No ☐ Yes
8. Does your child get picked on or teased? ☐ No ☐ Yes If yes, by whom: _____
9. Does your child get along with Mom? ☐ No ☐ Yes
10. Does your child get along with Dad? ☐ No ☐ Yes
11. Is there anything else to know about your child? _____

Child's Family History

Father Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Mother Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Sibling 1 Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Sibling 2 Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Sibling 3 Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Sibling 4 Age: ____ Significant health issue(s): _____ If deceased, age at death: _____ Cause: _____

Others living in home:

Other 1 Age: ____ Relationship to child: _____

Other 2 Age: ____ Relationship to child: _____

Other 3 Age: ____ Relationship to child: _____

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Has a blood relative ever had one of the following conditions?

Cancer	☐ No	☐ Yes	If yes, specify relative: _____
Tuberculosis	☐ No	☐ Yes	If yes, specify relative: _____
Diabetes	☐ No	☐ Yes	If yes, specify relative: _____
Heart Trouble	☐ No	☐ Yes	If yes, specify relative: _____
High Blood Pressure	☐ No	☐ Yes	If yes, specify relative: _____
Stroke	☐ No	☐ Yes	If yes, specify relative: _____
Epilepsy	☐ No	☐ Yes	If yes, specify relative: _____
Mental Illness	☐ No	☐ Yes	If yes, specify relative: _____
Suicide	☐ No	☐ Yes	If yes, specify relative: _____
Alcoholism	☐ No	☐ Yes	If yes, specify relative: _____

Mother's History

1. List any pregnancy or delivery problems the biological mother experienced: _____

   _____

2. Did the child's mother use any of the following during pregnancy?
   - **Illegal drugs** ☐ No ☐ Yes
   - **Prescribed medications** ☐ No ☐ Yes
   - **Alcohol** ☐ No ☐ Yes
   - **Tobacco** ☐ No ☐ Yes

Family Psychiatric History

Please select Child, Family, or both if they have experienced:

Depression	☐ Child ☐ Family	**Schizophrenia**	☐ Child ☐ Family
Manic Depression	☐ Child ☐ Family	**ADHD**	☐ Child ☐ Family
Post-Partum Depression	☐ Child ☐ Family	**Oppositional Defiant Disorder**	☐ Child ☐ Family
Suicide	☐ Child ☐ Family	**Conduct Disorder**	☐ Child ☐ Family
Anxiety	☐ Child ☐ Family	**Tourette's**	☐ Child ☐ Family
Agoraphobia	☐ Child ☐ Family	**Autism**	☐ Child ☐ Family
Other phobias	☐ Child ☐ Family	**Asperger's**	☐ Child ☐ Family
Obsessive Compulsive Disorder	☐ Child ☐ Family	**Alcoholism**	☐ Child ☐ Family
Other stress disorder	☐ Child ☐ Family	**Substance Abuse**	☐ Child ☐ Family
Anorexia	☐ Child ☐ Family	**Psychiatric Hospitalization**	☐ Child ☐ Family
Bulimia	☐ Child ☐ Family		

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More about Your Child

1. What brings you here today? _____
2. When did the problems begin? _____
3. What interventions have you tried with your child? _____
4. What impact have the problems had on the family? _____
5. Describe how your child functions in school: _____
6. How does your child get along with other children? _____
7. Has your child been treated for any psychological or emotional problems before now? ☐ No ☐ Yes
8. Has your child repeated a grade? ☐ No ☐ Yes If yes, which grade: _____
9. Has your child had psychological testing completed by the school? ☐ No ☐ Yes
10. Has your child had an Individual Education Plan (IEP)? ☐ No ☐ Yes
11. Did your child have any delays in learning to:
    - Crawl ☐ No ☐ Yes
    - Walk ☐ No ☐ Yes
    - Speak ☐ No ☐ Yes
12. Has your child used or tried:
    - Alcohol ☐ Used ☐ Tried
    - Tobacco ☐ Used ☐ Tried
    - Illegal Substances ☐ Used ☐ Tried
13. Is your child sexually active? ☐ No ☐ Yes
14. Have there been any recent stressors in the family? ☐ No ☐ Yes If yes, please explain:

_____

_____

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