KeyPoint 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 ☐ Glaucoma ☐ Ear/Hearing Problems
☐ Eye/Vision Problems ☐ Throat Problems ☐ Other
☐ Nose Problems/Nosebleeds

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Musculoskeletal

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

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Blood/Lymphatic System

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

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Circulatory/Cardiac Systems

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

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Endocrine System

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

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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

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Additional Questions

Have you ever had any surgeries? ☐ Yes ☐ No

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Have you had cancer? ☐ Yes ☐ No

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Any abnormal lab tests/results? ☐ Yes ☐ No

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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

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

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

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

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Other problems in infancy: ☐ Unknown

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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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