CHILD FOCUS
Strong families. Thriving communities.

MEDICAL HISTORY

Name of Client		Date	
DOB		Age	
Name of Person Completing this form		Relation to Client	

PRIMARY CARE PHYSICIAN	Check if None ☐
Practice	
Name	
Address	
Phone #	
Date of last physical	

OTHER PHYSICIAN/MENTAL HEALTH PROVIDER	Check if None ☐
Practice	
Name	
Specialty	
Address	
Phone #	
Date of last appointment	

DENTIST	Check if None ☐
Practice	
Name	
Address	
Phone #	
Date of last cleaning	

PLEASE DESCRIBE ANY CURRENT HEALTH / MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

HAVE YOU EVER HAD ANY HISTORY OF MEDICAL CONCERNS INCLUDING BROKEN BONES, INJURIES REQUIRING MEDICAL ATTENTION, SURGERIES OR HOSPITALIZATIONS? *IF SO, PLEASE PROVIDE DETAILS BELOW*
Check if None ☐

Client's Name: _____

CURRENT PRESCRIPTIONS MEDICATIONS *(include dose and frequency)*	PRESCRIBED BY

CURRENT OVER-THE-COUNTER MEDICATIONS *(include dose and frequency)*	CURRENT VITAMINS *(include dose and frequency)*	CURRENT SUPPLEMENTS *(e.g., Melatonin, Glucosamine, etc.) (include dose and frequency)*

PLEASE IDENTIFY ANY FAMILY MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY CONCERNS RELATED TO

Concern	Present	Past	Details
Vision	☐	☐	
Hearing	☐	☐	
Speech	☐	☐	
Dental	☐	☐	
Allergies	☐	☐	
Head Injury	☐	☐	
Eating	☐	☐	
Sleeping	☐	☐	
Weight Loss or Weight Gain	☐	☐	
Dietary Needs	☐	☐	
Learning / Education Concerns	☐	☐	
Reading / Literacy	☐	☐	

HEALTH HABITS	
Are you on a special diet?	☐ No ☐ Yes Explain:

Client's Name: _____

IS THERE ANYTHING ELSE YOU THINK WE NEED TO KNOW ABOUT YOUR HEALTH?

The information contained within this document is accurate and complete to the best of my knowledge. I understand that it is my responsibility, to notify Child Focus of any changes in medical history that may affect my treatment.

PRINT NAME OF PERSON COMPLETING FORM	RELATIONSHIP	SIGNATURE	DATE

(For office use only)

This Medical History has been reviewed by a nurse or physician. A review of the information provided by the parent/guardian ☐ does ☐ does not contain sufficient information to contraindicate use of Physical Crisis Intervention Hold (restraint).

If not contraindicated, Child Focus authorized staff may use a Physical Crisis Intervention Hold (restraint) only as a time-limited protective measure in a life-or safety-threatening situation, and only when de-escalation has failed or is not possible. A physical hold is only used until the client regains behavioral control, or until the appropriate law enforcement, safety, or other emergency service providers arrive on site, whichever is sooner. Parent/guardian is responsible for notifying Child Focus of any changes in medical history that may cause restraint to be contraindicated.

☐ I have requested the above person's health history of skin, eyes, ears and throat, respiratory system, circulatory system, endocrine system, GI, elimination, GU, neurological, musculoskeletal, surgeries and immunizations.

_____ _____

Signature Date

Diagnostic Impressions and/or Recommendations, if any:

_____

_____

_____