

MEDICAL HISTORY

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

PRIMARY CARE PHYSICIAN		Check if None <input type="checkbox"/>
Practice		
Name		
Address		
Phone #		
Date of last physical		

OTHER PHYSICIAN/MENTAL HEALTH PROVIDER		Check if None <input type="checkbox"/>
Practice		
Name		
Specialty		
Address		
Phone #		
Date of last appointment		

DENTIST		Check if None <input type="checkbox"/>
Practice		
Name		
Address		
Phone #		
Date of last cleaning		

PLEASE DESCRIBE ANY CURRENT HEALTH / MEDICAL CONCERNS FOR YOUR CHILD INCLUDING ANY CHRONIC MEDICAL CONDITIONS
<div style="height: 100px;"></div>
Check if None <input type="checkbox"/>

HAS YOUR CHILD EVER HAD ANY HISTORY OF MEDICAL CONCERNS INCLUDING BROKEN BONES, INJURIES REQUIRING MEDICAL ATTENTION, SURGERIES OR HOSPITALIZATIONS? IF SO, PLEASE PROVIDE DETAILS BELOW
<div style="height: 100px;"></div>
Check if None <input type="checkbox"/>

Client's Name: _____

CURRENT PRESCRIPTIONS MEDICATIONS <i>(include dose and frequency)</i>	PRESCRIBED BY

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

PLEASE IDENTIFY ANY FAMILY MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS	
<p>Check if None <input type="checkbox"/></p>	

DOES YOUR CHILD CURRENTLY OR HAVE THEY EVER HAD ANY CONCERNS RELATED TO

Concern	Present	Past	Details
Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Speech	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Loss or Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	
Dietary Needs	<input type="checkbox"/>	<input type="checkbox"/>	
Learning / Education Concerns	<input type="checkbox"/>	<input type="checkbox"/>	
Reading / Literacy	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH HABITS	
Are your child's vaccinations/immunizations up to date?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
Please provide a copy of immunization records, if possible.	*When immunization records are not available, CFI acknowledges that the school district maintains a copy of immunization records
Is your child on a special diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes Explain:

Client's Name: _____

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

The information contained within this document is accurate and complete to the best of my knowledge. I understand that it is my responsibility, as the parent/guardian, to notify Child Focus of any changes in medical history that may affect my child's treatment and/or may cause restraint to be contraindicated.

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:
