Health & Medical Questionnaire

Client's name: _____

Health Condition-Mark X to all that apply	Client	Parent	Sibling	Ext Fam	Notes
Allergies-Environmental					
Allergies-Food					
Allergies-Medicine					
Allergies-Other					
Anxiety					
Asthma/Breathing Problems					
Birth Defects or Congenital Conditions					
Blood-related problems					
Brain or Head Injury					
Cancer					
Dental problems					
Depression					
Diabetes					
Feeding problems					
Hearing Difficulty					
Heart Problems					
Learning Difficulties					
Mental illness (other type/s)					
Pregnancy/Delivery Complications					
Schizophrenia/Psychosis					
Seizures					
Sensory Over/ Under Sensitivity					
Skin Problems					
Sleep Problems					
Toileting Problems					
Vision Difficulties					
Other:					

Is your child receiving additional support (OT, Speech, tutor, etc)? Y/ N

Has any testing been done for your child (psychological, behavioral, educational)? Y/ N

Have you ever had an IFSP (pre-K)/IEP/504 plan or behavioral support plan in school? Y/ N

List any medications (Rx or OTC), herbal supplements or vitamins your child takes:

If there are other issues with health or development, please include this information below. If you have any testing results or reports, please bring copies to the first appointment to give to your therapist.

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Client's name: _____

Trauma History-Mark X to all that apply	**Client**	**Parent**	**Sibling**	**Ext Fam**	**Notes: Please include if witness, victim, or learned about**
Serious Accidental Injury					
Illness/Medical Trauma					
Community Violence					
Domestic Violence					
School Violence/Emergency					
Physical Assault					
Disaster					
Sexual Abuse					
Physical Abuse					
Neglect					
Emotional Abuse					
Impaired Caregiver					
Sexual Assault/Rape					
Kidnapping/Abduction					
Terrorism					
Bereavement/Grief/ Significant Loss					
Separation					
War/Political Violence					
Forced Displacement					
Trafficking/Sexual Exploitation					
Bullying					
Attempted Suicide					
Witnessed Suicide					
Other: please explain					
Substances	**Client**	**Parent**	**Sibling**	**Ext Fam**	**Notes: Current/Past? Experimentation/Use/ Abuse/Dependency**
Alcohol					
Cocaine					
Marijuana					
Methamphetamine					
Others:					