Vine School Health Center

Health and Family History Form

**This form is to be completed by child's legal guardian*

Vine School Health Center is a comprehensive medical and emotional health practice. Please complete the following form to your best ability. We use this information to help us provide the best services for your child through our care or our research.

Today's Date: _____ Child's Name: _____

Child's Date of Birth: _____ Child's Age:_____ Child's Gender: **Male or Female**

**Name of person completing this form and relationship to this child: _____ _____

Birth History:

1. Where was the child born? _____ Birth weight _____
2. Did the child/mother have any problems at birth? **Yes No Unknown**
   If yes, what were the problems? _____
3. Did birth mother abuse drugs during pregnancy? **Yes No Unknown**
   4. Did the child spend time in the NICU due to drug or alcohol exposure at birth? **Yes No Unknown**

Social History

5. Who lives in the home with the child? _____
6. Is the child currently homeless or ever experienced homelessness (ex. living in a shelter or unstable housing)? **Yes No Unknown**
7. Have the child's previous or current primary caregivers ever been separated or divorced, or has the child ever been raised in a single parent household? **Yes No Unknown**
8. Has any person in the child's previous or current immediate family ever been to, or currently in, prison/jail? **Yes No Unknown**
9. Has any person in the child's previous or current immediate family ever had a problem with drugs or alcohol? **Yes No Unknown**
10. Has any person in the child's previous or current immediate family ever attempted suicide **or** had a mental illness (ex. depression)? **Yes No Unknown**

Past Health History:

11. Has the child had any serious illness? **Yes No** Has the child ever been hospitalized? **Yes No**
    Has the child ever had a procedure/surgery? **Yes No**

If yes, please tell us about the illness, hospitalization, or surgery/procedure: _____

Abuse Screening:

12. Has the child **ever** been verbally abused (put down, devalued, or insulted)? **Yes No Unknown**
13. Has the child **ever** been physically abused? **Yes No Unknown**
14. Has the child **ever** been sexually abused or assaulted? **Yes No Unknown**
15. Has the child **ever** witnessed domestic violence (violence between family members) in the home? **Yes No Unknown**
16. If yes, is the abuse still occurring? **Yes No** If yes, please describe: _____

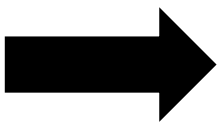
Present Health History:

17. Does the child take medication every day, either prescription or non-prescription? **Yes No**
    If yes, please describe_____
18. Does the child have any allergies to medicine, food, plants, or animals? **Yes No**
    If yes, please describe_____
19. Does the child exercise? **Daily At least weekly At least monthly Never N/A**

Emotional Health History:

20. Has the child often reported feeling neglected, not protected, or were his/her caregiver(s) ever unable to provide basic care? **Yes No Unknown**
21. Does the child often report feeling that no one in the family loves him/her or that he/she is not important? **Yes No Unknown**

NEXT



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Child Health History:

22. Does the child have asthma or difficulty breathing, TB, or use oxygen? **Yes No**
    If yes, please describe: _____
23. Does the child complain of headaches, stomach aches, and joint pain with no medical diagnosis to explain? **Yes No**
    If yes, please describe: _____
24. Has the child ever had any broken bones? **Yes No**
    If yes, please describe: _____
25. Has the child ever been diagnosed with a mental illness (ex. depression, anxiety, oppositional defiant, ADHD)? **Yes No**
    If yes, please describe: _____
26. Is the child intellectually challenged or have learning difficulties? **Yes No**
    If yes, please describe: _____
27. Does the child have behavioral problems? **Yes No**
    If yes, please describe: _____
28. Does the child use cigarettes (tobacco/e-cigs/vapors), alcohol, marijuana or other drugs? **Yes No**
    If yes, please describe: _____
29. Does the child have trouble with being underweight, overweight, or obese? **Yes No**
    If yes, please describe: _____

Family Health History:

***Does the child or any family members have….**

30. Any form of cancer? **Yes No** Child or Relationship to the child: _____
31. Stroke? **Yes No** Child or Relationship to the child: _____
32. Thyroid problems? **Yes No** Child or Relationship to the child: _____
33. Bone or muscles problems? **Yes No** Child or Relationship to the child: _____
34. Heart problems, heart attack, heart surgery? **Yes No** Child or Relationship to the child: _____
35. High cholesterol or take medicine for cholesterol? **Yes No** Child or Relationship to the child: _____
36. Asthma or difficulty breathing, TB, or use oxygen? **Yes No** Child or Relationship to the child: _____
37. Kidney stones, disease, surgery, or transplant? **Yes No** Child or Relationship to the child: _____
38. Weak immune system or frequent infections? **Yes No** Child or Relationship to the child: _____
39. Trouble with being underweight, overweight, obesity?
    Yes No Child or Relationship to the child: _____
40. Diabetes or blood sugar problems as a child or adult?
    Yes No Child or Relationship to the child: _____
41. Chronic headaches, seizures, or other neurological problems?
    Yes No Child or Relationship to the child: _____
42. Blood problems like anemia, sickle cell trait or sickle cell disease?
    Yes No Child or Relationship to the child: _____
43. Ulcers of the stomach, Crohn's disease, or other stomach or bowel problems?
    Yes No Child or Relationship to the child: _____
44. Hearing or vision problems such as deafness or blindness at birth or at a young age?
    Yes No Child or Relationship to the child: _____