Vine School Health Center

HEALTH AND HISTORY FORM

Vine School Health Center is a comprehensive healthcare and mental health practice. Please complete the following form to your best ability. We use this information, to 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 sex:	Child's Gender Identity:	

Health Questionnaire

Birth History:

How long was pregnancy? _____**WKS** **Full term** **Premature**

What hospital was the child born?

Birth weight? **Lbs** **oz**

Did the child/mother have any problems at birth? **Yes** **No** **Unknown**
If yes, what?

Did birth mother abuse drugs/alcohol during pregnancy? **Yes** **No** **Unknown**

If yes, did the child spend time in the NICU due to drug or alcohol exposure at birth? **Yes** **No** **Unknown**

Social History:

Who lives in the home with the child? (Circle all that apply)
Mother Father Grandparent Guardian Sibling(s) _____
Other:

Is the child currently homeless or ever experienced homelessness (ex. living in a shelter or unstable housing)? **Yes** **No** **Unknown**

Any person in the child's previous/current immediate family ever been to, or currently in, prison/jail? **Yes** **No** **Unknown**

Any person in the child's previous or current immediate family ever had a problem with drugs or alcohol? **Yes** **No** **Unknown**

Any person in the child's previous/current immediate family had a mental illness (depression/anxiety) or attempted suicide? **Yes** **No** **Unknown**

Heath History:

Medication Allergies: **Yes** **No**
Food Allergies: **Yes** **No**
Environmental Allergies: **Yes** **No**
If yes to any above, explain:

Any chronic/serious medical diagnosis? **Yes** **No**

Has the child had any serious illness? **Yes** **No**
Has the child ever been hospitalized? **Yes** **No**
If yes, please tell us about the illness, hospitalization, or surgery/procedure:

Medication taken on regular basis (prescription/non-prescription)? **Yes** **No**
If yes, please explain:

Please check if you have any following concerns for your Child:

☐ Asthma/wheezing	☐ Convulsions/seizures	☐ Joint Pain
☐ Heart	☐ Thyroid	☐ Anemia
☐ High Blood Pressure	☐ Diabetes or blood sugar	☐ Fractures
☐ Underweight	☐ Urinary tract infection	☐ Rashes
☐ Overweight	☐ Stomach issues/aches	☐ Fainting
☐ Headaches	☐ Concussion/Head Injury	☐ Hearing
☐ Eye/Vision	☐ Nose	☐ Throat
☐ Ear	☐ Developmental	☐ Behavioral

☐ Other:

Environmental Screener:

Has the child **ever** been verbally abused (put down, devalued, or insulted)? **Yes** **No** **Unknown**

Has the child **ever** been physically abused? **Yes** **No** **Unknown**

Has the child **ever** been sexually abused or assaulted? **Yes** **No** **Unknown**

Has the child **ever** witnessed domestic violence (violence between family members) in the home? **Yes** **No** **Unknown**

If yes, is the abuse still occurring? **Yes** **No**
If yes, please describe:

Has the child often reported feeling neglected, not protected, or were his/her caregiver(s) ever unable to provide basic care? **Yes** **No** **Unknown**

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**

Family History

Please Check the box of your child's blood relatives who have ever had any of the following conditions:	Father	Mother	Sibling	F Side	M Side
Asthma					
High Blood Pressure					
Heart attack before age of 50					
Stroke					
Any form of cancer?					
High cholesterol or take medicine for cholesterol?					
Kidney stones, disease, surgery, or transplant?					
Weak immune system or frequent infections?					
Diabetes or blood sugar problems as a child or adult?					
Ulcers of the stomach, Crohn's disease, or other stomach or bowel problems					
Chronic headaches, seizures, or other neurological problems.					