CHILD GUIDANCE CENTER

Helping kids find hope and healing

Child's Full Legal Name:______________________________ Date of Birth:______________

Child Guidance ID #:____________ Date:______________

This medical information questionnaire is very important to your child, you, and your therapist. Oftentimes the way we feel physically may be related to our emotions and behaviors, or vice versa. Additionally, it has been our experience that family physicians/pediatricians find it useful to know when their patients come to Child Guidance Center; therefore, there is a Release of Information form contained also.

MEDICAL INFORMATION

1. Is this child *ALLERGIC* to any medication? If so, please list the name of the medication and what happens if he/she takes it____

____

2. Does this child have any *OTHER* ALLERGIES? If so, what is he/she allergic to and what happens if he/she is exposed to it?____

____

3. If this child on any medication *NOW*? If so, what is the *name/s* of the medication/s, and *who prescribed it?*____

____

4. Has this child been on any medication in the last *SIX* months? If so, what was the name/s of the medication/s, and who prescribed it?____

____

5. Is this child taking any over-the-counter medications now? If so, what is the name/s of the medications?____

____

6. Does this child have any EATING/NUTRITION problems. If so, please describe the problems:______________

____

7. Does your child use tobacco products?

Cigarettes? Yes___ No___ How many?_________How long?_________

Chewing tobacco? Yes___ No___ How much?_______ How long?_______

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www.child-guidance.org

MEDICAL INFORMATION

Name of Child:________________________ Age:______ DOB:______________

Child Guidance ID #:________________________ Birth Weight______________

Were there complications during pregnancy and/or delivery? If yes, please explain____

____

Child's Physician's Name____

Office Address________________________City______________Zip__________

Office Phone Number________________________________

Please check any of the following your child now has or has had:

[ ] Chickenpox
[ ] Conjunctivitis (Pink Eye)
[ ] Ringworm (Tinea Capitis)
[ ] Impetigo
[ ] Staphylococcal Infection
[ ] Fifth Disease
[ ] Lyme Disease
[ ] Scabies
[ ] Rubella
[ ] Easy Bleeding or Bruising
[ ] Venereal Disease (specify)

____

[ ] Viral Hepatitis A
[ ] Viral Hepatitis B
[ ] Viral Hepatitis C
[ ] Shigella
[ ] Frequent Urinary Tract Infections
[ ] Diabetes
[ ] Anemia
[ ] Kidney Disease
[ ] Pancreatitis
[ ] Stomach Ulcer
[ ] Jaundice
[ ] Meningitis
[ ] Convulsions/Seizures/Epilepsy

[ ] Frequent Respiratory Infections
[ ] Asthma
[ ] Respiratory Syncytial Virus (RSV)
[ ] Hyperventilation
[ ] Tuberculosis
[ ] Allergies or Hay fever
[ ] Failure to Thrive
[ ] Alcoholism
[ ] Drug Dependency
[ ] Panic Attacks
[ ] Cancer
[ ] Rheumatic Fever
[ ] Heart Disease
[ ] Thyroid Disease
[ ] Birth Defects (specify)

____

[ ] Suicidal Thoughts
[ ] Tics
[ ] Depression
[ ] Recurring Nightmares
[ ] Problems Sleeping
[ ] Suicidal Thoughts

HISTORY

Are you aware of your child having any current contagious illness or disease? If yes, please explain.____

____

Does any other family member currently have a contagious disease or illness? If yes, please explain____

____

If this child has been hospitalized or had any surgery, please list:____

____

Is your child experiencing acute or chronic pain at this time? If so, where and how do you manage it?____

IMMUNIZATION HISTORY/RECORD

Child's Name_______________________________ DOB______________ CGC ID#_________________________

Date of child's last physical exam_____________________________ Today's date____________________________

1. Everyone should keep a personal immunization record. It can help you make sure that your child has the protection he/she needs against these diseases. It can also prevent needless re-vaccination during a health emergency or when you change doctors.

2. Routine checkups at your doctor's office or local health clinic are the best way to keep children healthy — even if your child is not sick.

3. By ensuring that your child gets immunized on schedule, you can provide the best defense against dangerous childhood diseases. Child hood immunization means protection from nine major diseases: hepatitis B, polio, measles, mumps, rubella (German measles), petussis (whooping cough), diphtheria, tetanus (lockjaw), and Haemophiles influenzae type b.

4. The chart below includes immunization recommendations form the American Academy of Pediatrics. Check with your doctor or health clinic to find out whether your child needs additional booster shots or if other new vaccines have been recommended. It could save a life or prevent a disability.

Please review the chart (left) and check below

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-14 years	15 years	16-18 years
Hepatitis B[1]	HepB	HepB		HepB[1]		HepB								
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP				
Haemophilus influenzae type b[3]			Hib	Hib	Hib[3]	Hib								
Inactivated Poliovirus			IPV	IPV		IPV				IPV				
Measles, Mumps, Rubella[4]						MMR				MMR				
Varicella[5]							Varicella							
Meningococcal[6]								Vaccines within broken line are for selected populations		MPSV4	MCV4		MCV4	
Pneumococcal[7]			PCV	PCV	PCV	PCV			PCV		PPV			
Influenza[8]						Influenza (Yearly)					Influenza (Yearly)			
Hepatitis A[9]										HepA Series				

[ ] My child's immunizations are current.______________________
Your Signature

[ ] My child immunizations are not up to date.__________________
Your Signature

[ ] Other. (Please explain)______________________

OFFICE USE ONLY

Reviewed by____Date______________

Reviewed by Dr.__________________________(if necessary)Date______________

05/06

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I do hereby authorize ______________________________ to release information and receive
(Child's Pediatrician/Family Physician)
information from Child Guidance Center concerning ______________________ Date of Birth__________
(Child's full legal name)
Child Guidance ID# ____________________, for the purpose of informing said party about the following: 1) treatment, 2) immunizations, 3) physical examination, 4) follow up, 5) discharge summary, and/or 6) other (specify)____.

The extent or nature of the information to be disclosed is the following: 1) immunization record, 2) childhood diseases, 3) hospitalizations/s, 4) injury/s, 5) history and physical examination, 6) treatment progress, 7) phone contact for treatment progress and/or 8) other__________________________.

This authorization is effective **through discharge** unless revoked or terminated earlier by the client/parent/guardian.

You may revoke or terminate this authorization by submitting a written revocation to the Child Guidance Center. You should contact the Outpatient Services Director to terminate this authorization.

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Child Guidance Center discloses it to another party.

Rights of the Individual

- You may request to inspect or copy information used or disclosed under this authorization
- You may refuse to sign this authorization

Effect of Refusing Authorization
If you refuse to sign this authorization, Child Guidance Center will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:______________________________

______________________________ Signature of Client/Parent/Guardian	______________________________ Signature of Witness
______________________________ Date	______________________________ Date
	______________________________ Child's signature (if applicable)
	______________________________ Date

05/06