# Child's Health Information

| | |
|---|---|
| Has the child ever (now or in the past) received treatment for any emotional or psychological problem? Problems may include but are not limited to Anxiety, Depression, Substance Abuse, Eating Disorder, ADHD, and Autism. | ◯ Yes<br>◯ No<br>◯ Don't know<br>((You will provide details below.)) |
| Has the child taken any medications (prescription or over-the-counter) within the past two weeks? | ◯ Yes<br>◯ No<br>◯ Don't know<br>((You will provide details below.)) |

**Please list all current and past treatment and/or evaluations the child has received for any emotional or psychological problem.**

Treatment 1

Problem:

_____

Type of treatment and/or medication:

_____

Start Date:

_____
((Indicate month and year.))

End Date:

_____
((Indicate month and year.))

Treatment 2

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 3

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 4

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 5

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 6

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 7

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 8

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 9

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

Treatment 10

Problem:

_____
((If no further treatments to report, leave blank.))

Type of treatment and/or medication:

_____
((If no further treatments to report, leave blank.))

Start Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

End Date:

_____
((Indicate month and year. If no further treatments to report, leave blank.))

**Please list all medications the child has taken within the past two weeks.**

Medication 1

Medication name:

_____

Reason for taking medication:

_____

Taken within the last 24 hours?

◯ Yes
◯ No

Medication 2

Medication name:

_____
((If no further medications to report, leave blank.))

Reason for taking medication:

_____
((If no further medications to report, leave blank.))

| | |
|---|---|
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |
| Medication 3 | |
| Medication name: | _____<br>((If no further medications to report, leave blank.)) |
| Reason for taking medication: | _____<br>((If no further medications to report, leave blank.)) |
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |
| Medication 4 | |
| Medication name: | _____<br>((If no further medications to report, leave blank.)) |
| Reason for taking medication: | _____<br>((If no further medications to report, leave blank.)) |
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |
| Medication 5 | |
| Medication name: | _____<br>((If no further medications to report, leave blank.)) |
| Reason for taking medication: | _____<br>((If no further medications to report, leave blank.)) |
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |

Medication 6

Medication name:

_____
((If no further medications to report, leave blank.))

Reason for taking medication:

_____
((If no further medications to report, leave blank.))

Taken within the last 24 hours?

◯ Yes
◯ No
((If no further medications to report, leave blank.))

Medication 7

Medication name:

_____
((If no further medications to report, leave blank.))

Reason for taking medication:

_____
((If no further medications to report, leave blank.))

Taken within the last 24 hours?

◯ Yes
◯ No
((If no further medications to report, leave blank.))

Medication 8

Medication name:

_____
((If no further medications to report, leave blank.))

Reason for taking medication:

_____
((If no further medications to report, leave blank.))

Taken within the last 24 hours?

◯ Yes
◯ No
((If no further medications to report, leave blank.))

Medication 9

| | |
|---|---|
| Medication name: | _____<br>((If no further medications to report, leave blank.)) |
| Reason for taking medication: | _____<br>((If no further medications to report, leave blank.)) |
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |
| Medication 10 | |
| Medication name: | _____<br>((If no further medications to report, leave blank.)) |
| Reason for taking medication: | _____<br>((If no further medications to report, leave blank.)) |
| Taken within the last 24 hours? | ◯ Yes<br>◯ No<br>((If no further medications to report, leave blank.)) |