Renaissance Center
Health Questionnaire For Children

Name: ______________________________
Client #: ____________________________
Date: _______________________________

Date of Birth: _________________________
Last Complete Physical Exam: ______________ ____________________________
Date Physical/Facility

Pediatrician: ____
Name, Address, and Phone Number

ALLERGIES:

	MEDICATION/SUBSTANCE	TYPE OF REACTION
1.	________________________________	________________________
2.	________________________________	________________________

PAST OR PRESENT ILLNESSES: (Circle any that apply)

1. Asthma
2. Bed wetting
3. Cancer
4. Diabetes
5. Head Injury/ Loss of Consciousness
6. Heart Problems/ murmur
7. Hepatitis
8. High Blood Pressure
9. Kidney Disease
10. Lung Disease
11. Prematurity
12. Seizure/ Epilepsy
13. Sexually Transmitted
14. Tuberculosis
15. HIV/AIDS
16. Sickle Cell or Other Blood Disorders
17. Other ________________

Do you have pain at present? **Yes** ____ **No** ____ if yes, describe and rate (1=slight pain to 10=serve pain)
____
____

Surgeries: ____
____

Over-the-counter-medicines taken regularly (for example: vitamins, aspirin, laxatives, etc.):
____

Prescription Medicines: ____
____

Circle answers to the following:

Tobacco Use: YES NO
Alcohol Use: YES NO
Other Drug Use: (e.g. street drugs) YES NO
Caffeine Use: (e.g. coffee, tea, chocolate, cola) YES NO

Sexually Active: (Circle) YES NO
Birth Control Method (male & female) ___________________________

FAMILY HISTORY:

1. Mental Health: ____
2. Mental Retardation: ____
3. Substance abuse: ____
4. Kidney disease: ____
5. Heart problems: ____
6. Cancer: ____
7. Diabetes: ____
8. Lung disease: ____
9. Other: ____

____________________________________	______________________
Client Signature	Date
____________________________________	______________________
Parent / Guardian Signature	Date
____________________________________	______________________
Counselor Signature	Date