ABA Care for Kids Behavioral Health Medical History Form

Youth's name_____ DOB _____ _

Primary Care Physician_____ **Phone number**_____ _

Primary Care Physician Address_____ _

Date of last physical_____ **Height**_____ **Weight**__ _

Date last treated by a physician_____ **Reason**_____ _

Has your child experienced any of the following:

1.	Head injury	Yes__ No__	10.	Dental problems	Yes__ No__
2.	Operations	Yes__ No__	11.	Speech problems	Yes__ No__
3.	Seizures	Yes__ No__	12.	Breathing problems	Yes__ No__
4.	Serious injury	Yes__ No__	13.	Skin problems	Yes__ No__
5.	Headaches	Yes__ No__	14.	GI problems	Yes__ No__
6.	Bedwetting	Yes__ No__	15.	Neurological problem	Yes__ No__
7.	Heart condition	Yes__ No__	16.	Lead problems	Yes__ No__
8.	Hearing problem	Yes__ No__	17.	Sickle cell trait	Yes__ No__
9.	Vision problem	Yes__ No__	18.	Other medical problem	Yes__ No__

If yes, explain:_____

_____

_____

Allergies to medication/food/environmental Yes__ No__

If yes, explain:_____ _

_____

Does youth have any medical conditions: Yes__ No__

If yes, explain_____ _

Youth currently taking medication Yes__ No__

If yes, please explain _____

Has youth taken medication in the past Yes__ No__

If yes, please explain _____

Is youth immunizations current Yes__ No__

Can you provide copy of immunization record Yes__ No__

Is youth experiencing pain Yes__ No__ Reason for pain. _____

If yes rate the pain from 0-10 _____ Youth been seen by doctor for pain Yes__ No__

Any significant weight loss during the past year Yes__ No__

If yes, please explain, _____

Does youth has any problems with eating Yes__ No__

If yes, please explain, _____

Signature: _____ Date: _____

Relationship to youth _____