CMHPSM Personal Health Record: Age 0-10 Years

To Be Filled Out/Completed by Adult for child/Consumer.

Consumer/Child Name: _____ DOB: _____

CRCT #:_____

☐ I decline to complete the Personal Health Review

History

Person providing information: ☐Self ☐ Parent ☐Guardian ☐ Foster parent

☐ Other specify: _____

Does your child have a Primary Care Provider? ○ Yes ○ No ○ Decline

(E.g. Doctor, Physician Assistant, Nurse Practitioner)

Name_____

If *No*, would you like help finding a Primary Care Provider? ○ Yes ○ No ○ Decline

Has your child seen your Primary Care Provider in the last year? ○ Yes ○ No ○ Decline

Has your child had any recent surgeries or medical procedures? ○ Yes ○ No ○ Decline

If *Yes*, what/when: _____

Has your child been hospitalized in the past year? ○ Yes ○ No ○ Decline

If *Yes*, please describe_____

Has your child gone to the emergency room in the last year? ○ Yes ○ No ○ Decline

How many times in the past year? ○1-2 ○ 3-4 ○ 5 or more times

If *Yes*, please describe: _____

Does your child have a dentist? ○ Yes ○ No ○ Decline

Have you seen your dentist in the last year? ○ Yes ○ No ○ Decline

Name of Dentist - _____

Does your child use specialized equipment or devices? ○ Yes ○ No ○ Decline

Examples include: wheelchair, walker, lift, CPAP, hearing aids, cochlear implants, glasses/contacts, oxygen

If *Yes*, please describe: _____

Is the equipment/device(s) in working order? ○ Yes ○ No

Do you need any assistance with the equipment/devices? ○ Yes ○ No

If *Yes*, please describe: _____

Are your child's immunizations up to date (flu, TDAP, Tetanus, Tuberculosis TB, HPV, Hep A)?

○ Yes ○ No ○ Unknown

If *No*, why? _____

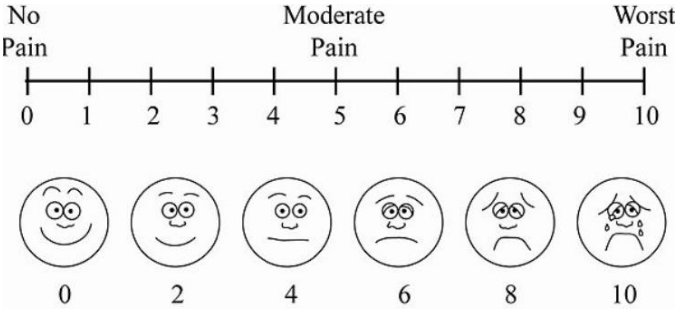
Has your child been in contact with anyone with Tuberculosis (TB)?

○ Yes ○ No ○ Unknown

Pain

Does ***your child*** experience pain that interferes with daily activities? ○ Yes ○ No

Please indicate ***your child's*** current level of pain:



Where is ***your child's*** pain? _____

Describe ***your child's*** pain: e.g.: dull, sharp, burning, pins & needles, tingling, throbbing, etc.

_____

How often does ***your child*** have pain?

_____

What does ***your child*** do to ease your pain? How does your child treat their pain?

_____

Health Conditions

Have you ever been told that *your child* has:

Asthma ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment:_____

Obesity ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: _____

Seizure Disorder ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: _____

Diabetes ○ Type 1 ○ Type 2 ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: _____

High Cholesterol ○ Yes ○ No ○ Decline

If *Yes*, please describe treatment: _____

Thyroid Issues ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____
Heart Disease ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment_____
High Blood Pressure ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____
Cancer ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____
Hepatitis ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____
Tuberculosis (TB) ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____
Other Medical Conditions not listed ○ Yes ○ No ○ Decline
If *Yes*, please describe treatment: _____

Does *<u>your child</u>* have SIBLINGS, PARENTS or GRANDPARENTS who have:

High Blood Pressure ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Hepatitis ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
High Cholesterol ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Heart Attack/Heart Disease ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Diabetes: ○ Type 1 ○ Type 2 ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Asthma ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents
Cancer ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐Grandparents
Tuberculosis (TB) ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐Grandparents
Seizure Disorder ○ Yes ○ No ○ Unknown
☐ Siblings ☐Parents ☐ Grandparents
Thyroid Issues ○ Yes ○ No ○ Unknown
☐ Siblings ☐ Parents ☐ Grandparents

Other Medical Conditions not listed? ○ Yes ○ No ○ Unknown

☐ Siblings ☐ Parents ☐ Grandparents

Please describe Other : _____

Wellness

In general, how would you rate your child's health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Decline to answer

How could you improve your child's health? _____

Does your child take medications as prescribed? ○ Yes ○ No ○ Sometimes ○ Decline

Female Only

Has your child started their menstrual period?_____

Age of First Period _____ Date: _____☐ Not Sure

Any problems? ○ Yes ○ No If *Yes*, explain: _____

If female, could your child be pregnant? ○ Yes ○ No ○ Decline to answer

Physical Activity

In the last **7 days**, how many times was your child:

Physically Active for at least 20 minutes in a day

○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days

What does your child do for physical activity? _____

Is there anything that keeps your child from physical activity? _____

Eat 3 or more servings of fruits or vegetables in a day

○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days

Diet

Does your child have a special diet? ○ Yes ○ No

(E.g. diabetic, low salt, pureed, thickened liquids, lactose-free, gluten- free, etc.)

If yes, what type of diet? _____

Does your child drink caffeinated beverages? *(E.g. soda, coffee, energy drinks, etc.)*

If yes, what type: _____ How much? _____

Eating problems? ○ Yes ○ No

Explain:_____

Allergies

Does ***your child*** have allergies to the environment *(e.g. cats, dogs, dust mites, etc.)?* ○ Yes ○ No

If *Yes*, explain_____

What is the reaction? _____

Does your ***child*** have any allergies to food(s)? ○ Yes ○ No

If *Yes*, explain_____

What is the reaction? _____

Does ***your child*** have any allergies to medications? ○ Yes ○ No

If *Yes*, explain_____

What is the reaction? _____

Symptoms

Check all that apply for ***your child***

☐ **Frequent headaches**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Confused or forgetful**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Head injury**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Mood changes**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Eye or vision problems**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Trouble hearing**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Teeth problems**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Finger or toenail problems**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Rashes or sores that do not heal**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Easily bruised/anemic**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No
☐ **Difficulty walking**	○ New Issue ○ Ongoing	
Are they receiving treatment?	○ Yes	○ No

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☐ **Falls** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Excessive thirst** ○ New Issue O Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Difficulty swallowing** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent nausea vomiting** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Coughing up blood** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Decrease in food intake/appetite** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Stomach pain/upset stomach** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent urination** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Painful urination** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Diarrhea** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Constipation** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Rectal bleeding** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Rapid/irregular heartbeat** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Chest pain/chest tightness** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Shortness of breath** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Wheezing** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent colds** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Persistent cough lasting over 3 weeks** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Sleep problems** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Weight gain of over 5 pounds in the *last month*** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Weight loss of over 5 pounds in the *last month*** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Weak or tired all the time** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Numbness or tingling** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Shaking or tremors** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Bed wetting** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Day wetting** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent nose bleeds** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent sore throats** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent sinus trouble** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Frequent ear aches** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

☐ **Soiling** ○ New Issue ○ Ongoing
Are they receiving treatment? ○ Yes ○ No

Please describe any of the "Yes" responses from the Symptoms:

_____

_____

Medications

Please list all prescribed medications, over- the- counter medications, vitamins, herbals, homeopathic medications

Medication Name	Strength e.g. how many milligrams, if known	Directions for use	Start Date (approximate)	Prescriber (or put OTC- for over- the-counter Meds)

Are **your child's** medications helpful?

○ Yes ○ No ○ Sometimes ○ Decline

If *No*, explain_____

Is ***your child*** have any side effects?

○ Yes ○ No ○ Sometimes ○ Decline

If *Yes*, explain_____

Is ***your child's*** prescriber aware of any concerns related to their medication?

○ Yes ○ No ○ Sometimes ○ Decline

Has ***your child*** taken other medications in the past to treat their conditions?

○ Yes ○ No ○ Sometimes ○ Decline

If *Yes*, explain_____

Has ***your child*** had labs drawn in the last 12 months?

○ Yes ○ No ○ Unsure

Vitals

Estimated Height _____ Feet ____Inches Estimated Weight _____pounds