Client #: _____

SEACOAST MENTAL HEALTH CENTER, INC.
CHILD AND ADOLESCENT MEDICAL SCREENING

Name: _____ Date of Birth: _____ Date: _____

Health Screening: (please check)	**No**	**Yes**	**Comments**
Does your child have any MEDICATION ALLERGIES?	☐	☐	If yes, please explain
Are your child's immunizations current and up to date?	☐	☐	If no, please explain.
Has your child had a physical exam within the past year?	☐	☐	If no, when was your child's last physical?
Has your child had any surgeries or hospitalizations?	☐	☐	If yes, please explain.
Has your child had any accidents, trauma, concussions, brain injury or seizures?	☐	☐	If yes, please explain.
Has your child had psychological, neuropsychological or neurological testing?	☐	☐	If yes, who performed the tests, and what were the results?
Does your child currently have any physical symptoms, complaints, or illnesses?	☐	☐	If yes, please explain.
Does your child have any dental symptoms, complaints, or illnesses?	☐	☐	If yes, please explain.
Does your child have any developmental problems (low birth weight, trauma during birth, developmental delays, fetal alcohol/drug exposure, etc.)?	☐	☐	If yes, how do these influence your child's current functioning?
Does your child have any chronic conditions or illnesses such as allergies, ear infections, or asthma?	☐	☐	If yes, please explain.
Is there any other information about your child's physical health or condition that we should know about?	☐	☐	If yes, please explain.

Name of:

Pediatrician: _____ Last Appointment: _____
Address: _____ Phone: _____
Dentist: _____ Last Appointment: _____
Other specialists (name, address, specialty): _____
_____
_____

Medications:

List any prescription medications, over-the-counter medications, vitamins, or dietary supplements your child is taking:

Name	Dose	Name	Dose

Nutritional screening: (please check)

	No	Yes	if yes, please explain.
Has a professional recommended that your child be on a special diet?	☐	☐	_____
Do you consider your child either over or underweight?	☐	☐	_____
Has your child's weight recently changed?	☐	☐	_____
Has your child's appetite recently changed?	☐	☐	_____

Height: _____ Weight: _____

Tuberculosis Screening: Has your child had any of the following symptoms in the past year?

	No	Yes
Productive cough lasting more than 2 weeks?	☐	☐
Coughing up blood or bloody sputum?	☐	☐
Significant weight loss without dieting?	☐	☐
Significant weakness?	☐	☐
Significant night sweats?	☐	☐
Significant fever?	☐	☐
Significant loss of appetite?	☐	☐

OB/GYN Screening (if applicable)

Age of first menstruation: _____

Date of last menstrual period: _____

Use of birth control: _____

History of pregnancy, abortion: _____

_____

_____

_____

_____ _____

Parent/Guardian Signature **SMHC Staff Signature**

Office use only _____

_____ No outstanding physical problems requiring further evaluation/assessment or treatment indicated, based on above information.

_____ Further information needed:

- _____ Additional information about _____.
- _____ Clearance from Dr. _____ needs to be obtained.
- _____ Records from Dr. _____ need to be obtained.
- _____ A physical exam/assessment is recommended.
- _____ The following labs or tests must be completed:

_____

Psychiatrist Signature **Date**