Patient Name_____ **DOB:**_____ **Pt#:**_____

School:
Grade:

Gender Identification / Sexual Orientation - At Generations Family Health Center, we want to take good care of you and your family. As a healthcare provider, there are certain questions we need to ask, to make sure we understand your needs. Please answer the questions below, the best that you can. If you don't want to answer these questions, you don't have to. But we really appreciate having the information, so we know better how to take good care of you. As always, we keep any information you give us private. Thank you!

What was your sex at birth? (please circle one) MALE FEMALE

GENDER IDENTITY **Do you consider yourself: check one**		**SEXUAL ORIENTATION** **(this is who you are attracted to)** **Do you consider yourself: check one**	
Lesbian or gay		Lesbian or gay	
Straight (not lesbian or gay)		Straight (not lesbian or gay)	
Bisexual		Bisexual	
Something else		Something else	
Don't know		Don't know	
Choose not to answer today		Choose not to answer today	

Note: Treatment will not be provided unless this form is completed and returned prior to the visit.

Medical/Dental History

1. Does this patient have any health problems currently being treated by a doctor □ Yes □ No
   If yes, explain: _____
2. Does this patient currently have a primary medical care provider □ Yes □ No
   If yes, enter doctor's name and address: _____
3. Date of last physical exam: _____ Where was last exam done _____
4. Has the patient ever been seen by a dentist before □ Yes □ No
   If yes, where and when_____
5. Date of last dental exam _____ Date of dental x-rays, if ever_____
6. Has the patient ever been told by a physician/dentist to take medicine before a dental procedure □ Yes □ No
   If yes, please explain: _____
7. Is the patient taking any medication (including non-prescription, over-the-counter medication or herbal remedies)□ Yes □ No
   List all medications and dosages (attach a separate sheet if necessary) _____
   _____
8. Does your Child have a history of any of the following, and if YES, please explain.

Y N	Asthma	Y N	Stomach or bowel problems
Y N	Allergy to any foods or medications	Y N	Seizures or fainting spells
Y N	Allergy to pain medications (pills/Novocain)	Y N	Frequent Cough
Y N	Hospitalizations or Surgeries	Y N	Endocrine or hormone problems
Y N	Tuberculosis	Y N	Frequent headaches
Y N	Diabetes	Y N	Liver (Hepatitis)
Y N	Disabilities	Y N	Recurrent infections
Y N	Heart murmur or defect	Y N	Hives or skin rash
Y N	Rheumatic fever	Y N	AIDS or HIV infection
Y N	Bleeds or bruises easily	Y N	Anemia or Sickle Cell Anemia
Y N	Allergy to Latex (gloves or band aids)	Y N	Vision problems
Y N	Child pregnant (females only)	Y N	Hearing problems
Y N	Current dental problem	Y N	Kidney problems
Y N	Problems with a previous dental experience?	Y N	Severe dental trauma
Y N	Problems with learning or understanding instructions	Y N	Religious or cultural beliefs which the provider should consider in planning treatment

9. How does the patient learn best? □ By reading □ By listening □ By demonstration □ By video □ Other: _____
10. Has the patient had / have any disease or condition not listed above? □ Yes □ No
    If yes, explain: _____

Child and Family Health History Reviewed By:

Provider Signature: _____ ***Date :***_____

Please continue to next page ➡

Provider Signature: _____ ***Date :***_____

Patient Name:_____ **DOB:**_____

School:
Grade:

ONLY FOR STUDENTS REGISTERING FOR BEHAVIORAL HEALTH SERVICES:
(For any questions that you answer YES, please explain details down below in the space provided.)

1. Does your child currently see a behavioral health clinician? YES NO If yes, tell us who: _____
2. Is your child currently prescribed any medications for a behavioral health condition? YES NO
3. If yes, please list the names and dosages: _____
4. If your child does not currently participate in therapy, has he/she ever received services in the past? YES NO
5. Has your child ever been treated by a therapist or diagnosed with symptoms of depression? YES NO
6. Has your child ever been diagnosed with or treated for symptoms of anxiety? YES NO
7. Is there a family history of mental health issues? YES NO
8. Has your child ever been diagnosed with a psychiatric issue? YES NO
9. Has your child ever been treated in a residential facility for psychiatric issues? YES NO
10. Does your child have a history of an eating disorder? YES NO
11. Has your child ever been hospitalized or treated for a suicide attempt? YES NO
12. Has your child ever reported thoughts about harming themselves? YES NO
13. Has your child hurt someone else or destroyed property within the past 6 months? YES NO
14. Does your child have any modifications in school such as an IEP or 504 plan? YES NO
15. Has your child ever been suspended or expelled? YES NO
16. Has your family ever been involved with the Dept. of Children & Families? YES NO
17. Has your child ever been arrested or on probation for an arrest? YES NO
18. Has your child ever witnessed or been the victim of abuse or neglect? YES NO
19. Does your child have any unusual eating habits? YES NO
20. Does your child participate in after school activities, sports or clubs? YES NO
21. Is the child able to form and maintain relationships with peers? YES NO
22. Is there currently any conflict in the family? YES NO

Comments: _____
_____
_____
_____

History review includes child and family health history on front of form.

_____ _____
Behavioral Health Provider Signature *Date*