New Horizons Mental Health Services Child Health History Form

Child name: _____ **Date of Birth:** _____ **Age:** _____

Height: _____ **Weight:** _____ D**ate of last physical exam:** _____

Medical condition(s) the child has been diagnosed with (check all that apply) ☐ None

Diagnosis	**ICD-10 Code** (Office Use Only)	**Client Past**	**Client Now**	**Doctor who diagnosed the condition**
		***	***	
Asthma	J45.909			
Liver Disease	K76.9			
Diabetes	E11.9			
Epilepsy	G40.909			
Seizures	R56.9			
Brain Injury	S06.9X9A			
Tumor	D49.6			
Heart Disease	I51.9			
Hepatitis	K75.9			
Stroke	I63.9			
HIV Positive	Z21			
Cancer (Please Indicate Type)				
			***	
Anemia	D64.9			
Arthritis	M19.90			
Bleeding Disorder	D68.9			
High Blood Pressure	I10			
Low Blood Pressure	I95.9			
Eye Disease	H57.9			
Fibromyalgia	M79.7			
Glaucoma	H40.9			
Headaches	R51			
Migraines	G43.909			
Hearing Loss	H91.90			
Kidney Disease	N28.9			
Lung Disease	J98.4			
Dental Issues	Z87.19			
Stomach	K31.9			
Bowel Problem	K 63.9			
Thyroid Dysfunction	E07.9			
Tuberculosis	A15.9			
Sexually Transmitted Disease	A64			
Learning Problems	F81.9			
Speech Problems	R47.9			
Eating Disorder	F50.9			
Sexual Problems	F52.9			
Sleep Disorder	G47.9			
Anxiety				
Bipolar Disorder				
Depression				
ADD/ADHD				
Schizophrenia				
Other:				

Is the child currently prescribed any medications by providers **NOT** employed by New Horizons or taking any over-the-counter medications, vitamins or herbals? ☐ No Current Medications

Medication	Dosage	Prescriber	Reason	How long has the child been taking this medication?

Does the child have any food or drug allergies? ☐ No Known Allergies

Drug/Food/Other	Please describe reaction/side effects

Is the child currently pregnant or has ever been pregnant? ☐ No

Date of Delivery/ Due Date	Is the child/did the child receive pre-natal care?	Complications

Has the child had any hospitalizations or surgeries in the past three years? ☐ None

Hospital	Reason/Procedure	Dates

Substance Use of Child – Current and Past History ☐ None

Substance	Never	Past Use	Current Use	How long has the child used?	Has the child received treatment? If so, where?
Alcohol					
Amphetamines					
Benzodiazepines					
Caffeine					
Marijuana/Cannabinoids					
Cocaine/Crack					
Hallucinogens					
Inhalants					
Nicotine					
Opiates/Heroin/Pain Medication					
OTC Medications					
PCP					
Prescription Medication					
Synthetic Drugs					

Sexual Orientation

Does the child think of themselves as:

- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Choose not to disclose

Gender identity

What is the child's current gender identity? (Check one):

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/ Female-to-Male (FTM)
- ☐ Transgender Female/Trans Woman/ Male-to-Female (MTF)
- ☐ Genderqueer/Non-binary, neither exclusively male nor female
- ☐ Additional Gender Category/(or Other), please specify: _____
- ☐ Choose not to disclose

What sex was the child assigned at birth on the original birth certificate? (Check one):

- ☐ Male
- ☐ Female
- ☐ Choose not to disclose