***PROVO CHILDREN'S HOME***

***Original: Individual's File***

# INTAKE MEDICAL RECORD

***An individual who is your patient has applied for intake within our organization. In order to assist us in adequately planning for the individual's medical care, please answer the following questions as accurately as possible. A consent form (S-2:4) to release this information has been signed by the individual and attached with this form.***
***This form is to be completed 30 days prior to intake.***

| Name of Patient: | Date of Birth: |
|---|---|
| Current Residence: | |
| Name of Doctor: | Telephone: |

How long has this individual been your patient?

## MEDICAL HISTORY:

Does the individual have any of the following illnesses at the present time?

| *MEDICAL STATUS* | *YES* | *NO* | *MEDICAL STATUS* | *YES* | *NO* | *MEDICAL STATUS* | *YES* | *NO* |
|---|---|---|---|---|---|---|---|---|
| Arthritis or Rheumatism | ☐ | ☐ | Glaucoma | ☐ | ☐ | Measles | ☐ | ☐ |
| Asthma | ☐ | ☐ | Emphysema or Chronic Bronchitis | ☐ | ☐ | German Measles | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | High blood pressure | ☐ | ☐ | Mumps | ☐ | ☐ |
| Heart trouble | ☐ | ☐ | Circulation trouble in arms or legs | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Ulcer of digestive system | ☐ | ☐ | Chicken Pox | ☐ | ☐ |
| Other stomach or intestinal disorders | ☐ | ☐ | Liver disease | ☐ | ☐ | Pertussis | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | Other urinary tract disorders | ☐ | ☐ | Scarlet Fever | ☐ | ☐ |
| Cancer or Leukemia | ☐ | ☐ | Anemia | ☐ | ☐ | Pneumonia | ☐ | ☐ |
| Effects of stroke | ☐ | ☐ | Parkinson's Disease | ☐ | ☐ | Hepatitis B Carrier | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Cerebral Palsy | ☐ | ☐ | Otitis Media | ☐ | ☐ |
| Multiple sclerosis | ☐ | ☐ | Muscular Dystrophy | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Effects of polio | ☐ | ☐ | Thyroid or other glandular disorder | ☐ | ☐ | Other (specify): | ☐ | ☐ |
| Skin disorder (press sore, leg ulcer, severe burns) | ☐ | ☐ | Past surgery (name): | ☐ | ☐ | | | |

Family Medical History (please list familial diseases such as heart, cancer, diabetes, etc.):

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## IMMUNIZATION:

Please list the individual's immunization history:

| *NAME* | *YES* | *NO* | *DATE* | *NAME* | *YES* | *NO* | *DATE* |
|---|---|---|---|---|---|---|---|
| DPT | ☐ | ☐ | | Measles | ☐ | ☐ | |
| Polio | ☐ | ☐ | | Hepatitis B | ☐ | ☐ | |
| Small Pox | ☐ | ☐ | | TB Skin Test | ☐ | ☐ | |
| Mumps | ☐ | ☐ | | Other | ☐ | ☐ | |

## DIETARY:

| |
|---|
| Please list any dietary restrictions: |
| Please list any special diet required for the individual: |
| Please list any food, drugs, inhalants or other allergies: |

## SEIZURES:

| |
|---|
| Type of Seizures: |
| Frequency: |
| Are seizures controlled by medication? |

## PHYSICAL DISABILITIES:

| |
|---|
| Does the individual have any physical disabilities (eg. total or partial paralysis, missing or non-functional limbs, broken bones)? |
| How is the individual's eyesight (totally blind, wears glasses, contacts)? |
| How is the individual's hearing (total, hearing loss, hearing aid, etc.)? |
| What supportive devices and prostheses does the individual use (eg. cane, walker, wheelchair, back brace, leg brace, colostomy equipment, catheter, hearing aid, kidney dialysis, etc.)? |
| List any aids (supportive or prosthetic devices) that would have to be purchased over the next 12 months. |

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## PSYCHOLOGICAL HISTORY:

| |
|---|
| Please tell us if the individual has significant psychological and behavioural disorders |
| Has the child suffered abuse, either sexual, physical, or emotional abuse |
| Please list all treatments that the individual may have received for nervous or emotional problems over the past one year. |
| Does the individual have any learning disabilities (eg. ADHD, Dyslexia, Autism)? |

## SPECIAL NEEDS

| |
|---|
| Does the individual need assistance with special care (eg. bathe, dress, feeding, toilet care, etc.)? |
| In the past year, has the individual received any physical therapy (if yes, how many hours per week)? |
| Please review individual's medical history and tell us if there are recurring medical conditions that we should be aware of (including eyes, ears, abdomen, cardia-pulmonary, musculoskeletal, neurological and genitourinary)? |

## MEDICATION:

Please list the drugs that the individual is currently taking (including psychotropic and P.R.N. drugs).

| *GENERIC NAME* | *TRADE NAME* | *DOSE* | *SIDE EFFECTS TO REPORT TO A DOCTOR* |
|---|---|---|---|
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# Social Services

Child's Name _____

Case Worker: _____

Application Date: _____ Conference Date: _____

Placement Date: _____ Review Date _____

**Behavioural Issues**

Please describe known behavioural issues such as lying, acting out, anger, violent behaviour, sexually inappropriate behaviour.

_____

_____

_____

_____

**Education**

School _____

Grade Level: _____ Teacher: _____

Academic Achievement: _____

Favourite Subject _____

Goals _____

Favourite Leisure Activity _____

Comments _____

_____

**Please provide a letter of introduction and authorization permitting access to information from the school.**