

Adolescent Initial History (11-20 yrs)

Today's date _____

Full Legal Name: _____

Date of Birth _____



Please complete the following questions: Indicate Yes/No or Check any that apply.

Birth History:

What was your birth weight? _____ lbs _____ oz Was the birth: ___ Vaginal ___ Cesarean section

Blood Type: ___ A ___ B ___ AB ___ O ___ Positive ___ Negative

Were there complications at birth? ___ Prematurity ___ Newborn Infection ___ Jaundice ___ Maternal diabetes ___ None
If any other complications, please explain: _____

Did you have any developmental problems? ___ Yes ___ No Check any that apply.
___ Delayed speech ___ Delayed walking ___ Poor growth ___ Poor weight gain ___ Other: _____

Medical History:

Do you have any allergies to medicines? ___ Yes ___ No

Name medicine and type of reaction _____

Do you have any health problems? ___ Yes ___ No List Problems: _____

Have you ever been hospitalized for an illness, operation, or injury? ___ Yes ___ No
If yes, give age and reason. _____

Have you had any serious injuries? ___ Yes ___ No
If yes, give age and describe injury _____

Do you take any medications regularly? ___ Yes ___ No
List medications: _____

Have you personally used (the ones used) ___ tobacco, ___ illegal drugs/substances, ___ alcohol? ___ None used

Do you exercise regularly? ___ Yes ___ No Type of exercise: _____ (ex: swimming, jogging)
Frequency of exercise _____ (ex: 3 days a week)

Indicate amount of time spent watching TV and/or playing Computer Games: ___ hours a day ___ minutes a day

Check any of the following problems you may have had. Check any that apply.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Headache | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> STD's | <input type="checkbox"/> Scoliosis/back problems | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | Other: _____ | If None Apply <input checked="" type="checkbox"/> box <input type="checkbox"/> | |

List any specific health concerns you may have: _____

Family History:

If family member has had a history of these illnesses, Check to indicate.

	Cancer	Cholesterol	Diabetes	High Blood Pressure	Heart Disease	Alcoholic	Drug Abuse	If None Apply <input checked="" type="checkbox"/> box
Father	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>
Mother	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>
Brother	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>
Sister	_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/>

With whom do you live? ___ Mother/Father ___ Stepparent ___ Relative ___ Other: _____

Changes in your household/family in the past year: _____
Example: Marriage, Illness, Births, Divorce, Death, Separation, Loss of job

Have you ever lived away from home? Explain _____

Are any of the following used in the home? : ___ Tobacco ___ Alcohol ___ Illegal Drugs ___ Guns ___ NONE

Are these available in the home?: ___ Telephone ___ Automobile ___ Thermometer ___ NONE

Form filled out by: ___ Adolescent ___ Parent/guardian ___ Other _____ Form Complete: _____ (staff initials)