YA HEALTH HISTORY (13 – 17 years old) Confidential Information Form

Bethany Bachmann LLC

General Information

Today's Date: _____

Child's Name:_____ DOB: _____

Parent/Guardian Name(s): _____

Address:_____

Phone:_____ Email:_____

Referred by: _____

Emergency Contact: _____ Phone: _____

What is the problem(s) for which you are seeking help for your child?

_____

_____

What are the goals in our work together for your child?

_____

Is your child under the supervision of a pediatrician for any health concerns? ( )Yes ( )No

If yes, for what?

_____

Any current medications? ( )Yes ( )No

If yes, which? For what?

_____

Is your child currently seeing a Mental Health Counselor? ( )Yes ( )No

Activities & interests your child enjoys (playing outside, crafts, games etc.):

_____

HEALTH HISTORY *Please check all conditions that apply to you (now or in the past).*

_____ Allergies (topical/internal)
_____ Anemia
_____ Aneurysm
_____ Anxiety
_____ Appetite/Weight Changes
_____ ADD/ADHD
_____ Arthritis
_____ Autism
_____ Asthma/Shortness of Breath
_____ Blood Clots
_____ Bowel/Bladder Problems
_____ Blood Pressure (high/low)
_____ Cancer/Tumors
_____ Cerebral Palsy
_____ Circulatory Problems
_____ Concussion
_____ COPD (Respiratory)
_____ COVID-19
_____ Depression
_____ Dentures
_____ Diabetes
_____ Digestive/Gut Problems
_____ Dislocations
_____ Dizziness/Vertigo
_____ Drug/Alcohol Addiction
_____ Eating disorders
_____ Fatigue
_____ Fibromyalgia
_____ Fractures
_____ Headaches
_____ Head Injuries
_____ Heart Condition
_____ Hepatitis
_____ Herpes/Cold Sores
_____ HIV/Aides
_____ Hysterectomy
_____ Jaw Pain/TMJ
_____ Kidney Problems
_____ Learning Disabilities
_____ Lyme Disease
_____ Major Dental Work
_____ Memory Problems
_____ Migraines
_____ Multiple Sclerosis
_____ Neck/Back Injuries
_____ Orthodontics
_____ Osteoporosis
_____ PMS
_____ PTSD
_____ Pacemaker
_____ Reproductive Health
_____ Ringing in Ears (Tinnitus)
_____ Seizures/Epilepsy
_____ Sensory Loss/Change
_____ Shingles
_____ Sinus Problems
_____ Skin Problems
_____ Stroke
_____ Teeth Clenching/Grinding
_____ Thyroid Disorder (high/low)
_____ Traumatic Brain Injury (TBI)
_____ Tuberculosis
_____ Varicose Veins
_____ Visual Disturbances

Is your child currently pregnant? ( )Yes ( )No

If yes, what trimester? _____

Any other medical history you would like me to be aware of? (significant family history, surgeries, injuries, accidents, falls, mental health, illness etc.):

_____

_____

Birth History (what do you know about your child's birth):

_____