Health Summary

Directions: Please fill out form to the best of your ability. If you are not sure about some items or do not know them, please indicate so on the form and we will help you to complete it at your appointment.

Name _____ DOB _____ SSN _____

Address: Street _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Guardian/Medical Surrogate_____
Relationship Phone#

Primary Insurance_____
Policy# Case Manager Phone#

Secondary Insurance_____
Policy# Case Manager Phone#

Pharmacy_____
Name Phone#

Unique Communication/Cultural Needs_____
Strengths/Assets_____

Please list pertinent family history_____

Allergies (meds/food)_____

Height_____Weight_____Dietary/Nutrition Needs_____

Bladder/Bowel Status: 1) Independent? Y/N _____ 2) Continent? Y/N _____

3) Problems in the past? Y/N _____Explain_____

Diagnoses/Health Problems: ☐ **Unknown** ☐ **N/A**

Diagnosis/Problem	Physician	Address	Phone #
1.			
2.			
3.			
4.			

5.			
6.			

Medications: ☐ Unknown ☐ N/A

Name	Dose	Frequency	Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

How does the patient take his/her medications? ☐By mouth ☐By G-tube ☐Takes liquids only
☐ Independently ☐Needs some assistance ☐Requires caregiver to give ☐Other: Type_____

Please list medications patient has tried and why they didn't work_____

_____

Therapies (Speech, Physical, Occupational, etc.): ☐ Unknown ☐ N/A

Current Therapies	Frequency	Provider	Phone#
1.			
2.			
3.			

Recent Important Diagnostic Tests: ☐ Unknown ☐ N/A

Recent Labs/Tests/X-rays	Date	Completed Where	Findings
1.			
2.			
3.			
4.			

Medical Equipment & Supplies Currently in Use/Needed: ☐ Unknown ☐ N/A

Medical Equipment	Medical Supplies	Provider	Phone#
1.			
2.			
3.			
4.			

Orthotics/Prosthetics Currently in Use/Needed: ☐ Unknown ☐ N/A

Device	Provider	Phone #
1.		
2.		

List Hospitalizations (including surgeries) Within the Last Year: ☐ Unknown ☐ N/A

Date	Hospital Name	Reason	Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What are your functional capabilities? (ex: walks w/o assistance, needs assistance, etc.):
☐ Unknown ☐ N/A

Upper Extremities:
Lower Extremities:
Bathing/Toileting:
Cognitive/Problem Solving:
Vision/Hearing:

Immunizations: ☐ Unknown

Last Immunization(s) Received:	**Date:**
Next Immunization(s) Due:	**Date:**

Other Community Services: ☐ Unknown ☐ N/A

Do you or the patient receive any of the following services? Please check all that apply:

☐ CMS ☐ WIC ☐ Food Stamps ☐ APD/Med Waiver ☐ Other: Type_____

Transition (ages 12 and up): ☐ Unknown ☐ N/A

What future plans do you have for the following areas once you are out of school and pediatric care? (eg: transitioned, agencies involved, referrals, appointments made)
Health Care:
Health Insurance:
School & Work:
Independent Living (housing, transportation, etc.):

Youth/Guardian Signature_____Date_____