Amani Center -Client Information-

REVISED 2014

Dear Parent/ Caregiver,
To prepare for your child's medical evaluation, we would like to know about your child's medical history. Please answer the following questions as well as you can. Thank you for your cooperation.

Date: _____ Name of Person filling out form: _____ Relationship to Child: _____

Child's Information:

Name: First_____ Middle_____ Last _____
Gender: ☐Male ☐Female Date of Birth: _____/_____/_____ Age: _____

Medical Information:

Child's Regular Health Care Provider (Dr., PA-C, FNP, etc): _____
Clinic name & address (provide as much as possible): _____
Approximate date of last visit? _____ Reason for last visit: _____

Child's Dentist: _____ Does Child have regular dental care? ☐Yes ☐No
Clinic name & address (provide as much as possible): _____
Approximate date of last visit? _____ Reason for last visit: _____

Pregnancy History:
Was the child born: ☐On time ☐Early ☐Late
What was the child's birth weight? ____lbs. ____oz.
How was the child born: ☐Vaginal ☐Caesarean section
Were there any problems with the pregnancy or delivery? ☐Yes ☐No
If yes, please explain: _____
Did the mother have regular prenatal care? ☐Yes ☐No When did care begin? _____
Were any substances used during pregnancy? ☐Alcohol ☐ Prescription drugs ☐Street drugs ☐Cigarettes ☐None
Did the child go home from the hospital with mother? ☐Yes ☐No
If no please explain: _____
Were there any problems after birth? ☐Yes ☐No
If yes please explain: _____

Development:
Have there been any concerns about the child's ☐ sight, ☐ hearing, ☐ speech?
If yes, please explain_____
How old was the child when he/she walked? _____When talked? _____
How old was child when toilet trained?_____Who helped with toilet training?_____

Medical History of Child:

Has the child ever had any of the following:			**If yes, age**	**Explanation**
☐Yes	☐No	Overnight hospitalization/ER visits	_____	_____
☐Yes	☐No	Surgery (ear tubes, hernia, tonsils, etc.)	_____	_____
☐Yes	☐No	Major injury/accident	_____	_____
☐Yes	☐No	Serious head injury, brain diseases	_____	_____
☐Yes	☐No	Stitches/broken bones/bone diseases	_____	_____

Has the child ever had any of the following: **If yes, age** **Explanation**

☐Yes ☐No Burns/accidental poisonings/overdose _____ _____

☐Yes ☐No Bleeding disorders / bruising problems _____ _____

☐Yes ☐No Developmental concerns or Evaluations _____ _____

Does the child currently have, or ever had, any of the following: **If yes, age** **Explanation**

☐Current ☐Past ☐Never Breathing problems _____ _____

☐Current ☐Past ☐Never Heart problems _____ _____

☐Current ☐Past ☐Never Allergies**(including food)** &/or skin problems _____ _____

☐Current ☐Past ☐Never Musculoskeletal problems _____ _____

☐Current ☐Past ☐Never Nausea/vomiting _____ _____

☐Current ☐Past ☐Never Constipation/diarrhea _____ _____

☐Current ☐Past ☐Never Burning or pain with peeing _____ _____

☐Current ☐Past ☐Never Daytime wetting _____ _____

☐Current ☐Past ☐Never Night time wetting _____ _____

☐Current ☐Past ☐Never Pooping or soiling accidents _____ _____

☐Current ☐Past ☐Never Bladder/kidney/urinary tract infections _____ _____

☐Current ☐Past ☐Never Redness/rashes/sores on genitals, anus or buttocks, (front or back private areas) _____ _____

☐Current ☐Past ☐Never Pain/itching of genitals, buttocks, or anus _____ _____

☐Current ☐Past ☐Never Discharge/bleeding from genitals or anus _____ _____

☐Current ☐Past ☐Never Any injuries to genitals, buttocks or anus_____ _____

List any other medical concerns or problems (chronic illness, asthma, seizures, bleeding problems, ADHD, etc.)

_____

_____

What words does child use for private areas? Penis: _____ Buttocks/anus: _____

Vagina/female genitals (front private parts): _____ Breasts: _____

Menstrual history *(if applicable):* Date of first period: _____ Date of last period: _____

Does she use: ☐pads ____ per day ☐tampons ____ per day Has she ever missed a period: ☐Yes ☐No ☐Unknown

Does she have pain with her period? ☐Yes ☐No ☐Unknown

Does she use medication for the pain? ☐Yes ☐No ☐Unknown

If yes, what type? _____ Is the medication taken effective? ☐Yes ☐No ☐Unknown

To assist us in knowing what labs *if any* may be needed, please answer the following:

Does the child's caregiver(s) have/had any sexually transmitted diseases? ☐Yes ☐No ☐Unknown

Does the alleged perpetrator(s) have/had any sexually transmitted diseases? ☐Yes ☐No ☐Unknown

Does the child have allergies to any medications? ☐Yes ☐No ☐Unknown

If yes, please explain: _____

Does the child take any medications daily? ☐Yes ☐No ☐Unknown

If yes, please explain: _____

Are the child's immunizations up to date? ☐Yes ☐No ☐Unknown

If no, please explain: _____

Family Medical History:

Has anyone in Child's family been diagnosed with:			If yes, who	Explanation
☐Yes	☐No	Asthma/breathing problems	_____	_____
☐Yes	☐No	Heart disease (heart attack, high blood pressure, stroke, etc.)	_____	_____
☐Yes	☐No	Seizures/ Brain or Nerve diseases	_____	_____
☐Yes	☐No	Arthritis	_____	_____
☐Yes	☐No	Diabetes/ Thyroid disease	_____	_____
☐Yes	☐No	Bone disease/ Bleeding disorders	_____	_____
☐Yes	☐No	SIDS	_____	_____
☐Yes	☐No	Cancer	_____	_____

Additional Information:

Have there been any significant stresses in the child's family (such as death, major illness, conflict between family members, divorce, job loss, moves, etc) in the last year? Please explain:

_____
_____

Do you have any questions or concerns about today's evaluation? _____
_____
_____
_____

Demographic Information

The Amani Center is a non-profit organization dedicated to the prevention, assessment, and treatment of child abuse and neglect. Because we do not charge families for our services, a large percentage of our funding comes from local, state, and federal grants. These grants often require us to provide demographic information (age, race & ethnicity, income levels, etc) for the families we see. We would appreciate you filling in the following information, as it will assist us in obtaining additional funding so that we can continue to provide the highest level of service to our community. This information will be used for grant writing purposes only, and will remain confidential. Thank you for assisting us.

1. **Annual Family Income (before taxes):**

   ☐ < $10,400 per year (< $867/month)
   ☐ $10,400- $13,999 per year ($1,167 per month)
   ☐ $14,000- $17,599 per year ($1,467 per month)
   ☐ $17,600- $21,199 per year ($1,767 per month)
   ☐ $21,200 - $24,799 per year ($2,067 per month)
   ☐ $24,800- $28,399 per year ($2,367 per month)
   ☐ $28,400- $31,999 per year ($2,667 per month)
   ☐ $32,000- $35,600 per year ($2,967 per month)
   ☐ > $35,600 per year (> $2,967 per month)

2. **Number of people supported by the income listed above? _____**

3. **Race/Ethnicity (Mark all that apply):**
   ☐White/Caucasian ☐Hispanic or Latino ☐Black/African American ☐Asian
   ☐American Indian/ Alaskan Native ☐Native Hawaiian/Pacific Islander ☐Other _____

ATTENTION STAFF: DO NOT FILE IN MEDICAL FILE.
PLEASE PLACE IN AGENCY DEMOGRAPHIC STATISTICS FILE.