Original Date:
Dates Revised:

Patient's Nickname:_____

PARENT SIGNATURE:_____**PROVIDER SIGNATURE:**_____

PEDIATRIC COMPREHENSIVE CARE PLAN

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient Name *(Last,First, M.I.):*	☐ M ☐ F	**DOB:**
Parents/caregiver name	**E-mail:**	
Address:	**Home phone:**	**Cell:**
School name:	**School phone/fax:**	**/**
Key Teacher contact:	**Teacher email:**	

PERSONAL HEALTH HISTORY

Allergies:		
Diagnosis	**Primary:**	**Secondary:**
	Medications/Dose:	Medications/Dose:
	Medications/Dose:	Medications/Dose:
List any medical problems that other doctors have diagnosed		

Specialists:		
Type	Reason	Clinic/Hospital &Year
Hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Are your meals well rounded?		Do you eat fruits and/or veggies every day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol/Smoking	Do you drink alcohol?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day			
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active				☐ Yes	☐ No
	Do you utilize a barrier method (condom)				☐ Yes	☐ No
Personal Safety	Have you broken an bones?					
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Do you feel depressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Stomach pain	☐ **Recent changes in:**
☐ Head/Neck	☐ Bladder	☐ Weight
☐ Ears	☐ Bowel	☐ Learning
☐ Nose or Throat	☐ Sensory	☐ Ability to sleep
☐ Heart	☐ Vision	☐ Other
☐ Lungs	☐ Hearing	

GOALS	
HOME:	
SCHOOL:	

NEGOTIATED PLAN TO REACH GOALS	
1	
2	
3	

STRENGTHS & PREFERENCES		
CHILD		**FAMILY**

DATES OF EVALUATIONS		
	ADDITIONAL SCHOOL TESTING:	
	TEACHER VANDERBILTS GIVEN	PARENT VANDERBILTS GIVEN
	TEACHER VANDERBILTS RETURNED	PARENT VANDERBILTS RETURNED
	Other:	

I understand and agree to the goals and services outlined in this treatment plan and I have been given the opportunity to give my input into developing this plan. We have discussed potential risks and benefits of the recommended treatments, as well as treatment alternatives. I acknowledge receipt of a copy of this plan and that any disclosure of the plan by me is not the responsibility of my care team or Gerald L Ignace Indian Health Center. Client Signature_____ Parent Signature _____ Provider:_____