Children's MINNESOTA | Partners in Pediatrics

MEDICAL HISTORY FORM
ADULT WORK/SCHOOL PROGRESS EVALUATION

(Parent may help complete if desired)

Date form filled out: _____

Your Name: _____ Birthdate: _____

Primary Phone: _____ Secondary Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

School/Other Address: _____

City: _____ State: _____ Zip: _____

Best Address and Phone number to reach you at: _____

Name of School/Work: _____ Year Expected Graduation: _____

Referred by: _____

Your private physician: _____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

Date | Name of physician, psychologist, agency, or clinic

_____

_____

_____

Please list the problems with which you want help for yourself:

1. _____
2. _____
3. _____
4. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

_____

_____

Name: _____ Date of Birth: _____

EDUCATIONAL SITUATION/JOB STATUS

Please describe your current classroom placement and services (attach copies of any school psycho-educational reports if available):

School performance: What has your school/employer told you about the following:

Behavior? _____

Work completion? _____

Academic progress? _____

Handwriting/neatness: _____

Please describe previous school problems:

Grade/year	School/Center name	Problems

Please describe previous work problems:

Employer name	Problems

HOME/FAMILY

1. Briefly describe any behavior or family issues that bother you:

2. Please describe any conflict surrounding homework/work/studying: _____

Name: _____ Date of Birth: _____

SOCIAL

1. How many close friends do you have? _____
2. Describe any problems you may have in making and keeping friends: _____
3. Please describe any aspect of your social life that bothers you: _____

SELF-ESTEEM

How do you feel these problems are affecting your self-esteem? _____

PAST MEDICAL HISTORY

Were there any problems when your mother was pregnant with you? ☐ Yes ☐ No
If yes, describe: (ex. Low birth weight)

Were there any problems during your newborn period? ☐ Yes ☐ No

GROWTH / NUTRITION

Have you had any problems with: (if Yes, please describe)

Growth in height: ☐ No ☐ Yes: _____

Weight loss or gain: ☐ No ☐ Yes: _____

Additional details or comments: _____

DEVELOPMENT

Was your development normal compared to other children? ☐ Yes ☐ No Describe:
Age you first walked _____
Age you spoke your first word _____

Are your immunizations up-to-date? ☐ Yes ☐ No
(Please include a copy of current immunization records)

Describe any serious reactions: _____

Name: _____ Date of Birth: _____

List any known allergies to medications, foods, pollens, or inhalants: _____

_____

Describe any hospitalizations or surgery (date, reason, problems): _____

_____

_____

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): _____

_____

_____

_____

SOCIAL HISTORY

	Family member/name	Years of school	Occupation
Father:			
Mother:			
Stepfather:			
Stepmother:			

Parents are: ☐ married ☐ separated ☐ divorced ☐ never married

Please share any history of significant (if any) marital problems: _____

_____

I am ☐ in a relationship ☐ married ☐ separated ☐ divorced ☐ never married ☐ not in a relationship

Where do you live and with whom? _____

BEHAVIOR HISTORY:

If the patient has experienced any of these behavior problems, please record the ages they occurred:

BEHAVIOR	NO	YES	AGES
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Explain any behavior problems listed above:

_____

_____

_____

_____

Name: _____ Date of Birth: _____

FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family *other than yourself* may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

FAMILY HISTORY	Your mother	Your father	Your brother(s)	Your sister(s)	Others (Specify)
LEARNING					
Difficulty learning to read					
Difficulty with arithmetic					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Mental retardation					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
Heart attach/stroke before age 55					
Sudden/unexplained deaths before age 40					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

Father's age: _____

Mother's age: _____

Sister(s) names and ages: _____

Brother(s) names and ages: _____

Name: _____ Date of Birth: _____

FAMILY HEART HISTORY:

If a member of your family has had any of these medical problems, please record their relationship to you.

PROBLEM	NO	YES	RELATIONSHIP
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

PERSONAL HEART HISTORY:

If you have experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

REVIEW OF SYSTEMS

Please list currently prescribed or over-the-counter medications taken and their doses:

_____ _____

_____ _____

_____ _____

Name: _____ Date of Birth: _____

If you have experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Heart murmur			
Irregular heart beat or palpitations			
Fainting			
Chest pain			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods – age at onset _____ Problems?			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other:			

Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

SCHOOL (WORK) EVALUATION INITIAL SELF REPORT

Name: _____ Date of Birth: _____

Today's Date: _____ Your Phone Number: _____

- Please summarize your main concerns: _____
  _____
- When did these difficulties begin? _____
- How has this affected your schoolwork and/or job? _____
  _____
- How has this affected your relationship with your family? _____
  _____
- How has this affected your relationship with your friends, classmates, team members, or coworkers?
  _____
  _____
- Have you been on medication for ADHD, Depression, Anxiety, or Mental Health in the past? ❒ Yes ❒ No
  If yes, when and how treated? _____

Directions: When completing this form, please think about your behaviors in the past 6 months.

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. I do not pay attention to details or make careless mistakes with, for example, homework or other work.	0	1	2	3
2. I have difficulty keeping attention to what needs to be done.	0	1	2	3
3. I do not seem to listen well when spoken to directly.	0	1	2	3
4. I do not follow through when given directions and fail to finish activities.	0	1	2	3
5. I have difficulty organizing tasks and activities.	0	1	2	3
6. I avoid, dislike, or do not want to start tasks that require ongoing mental effort.	0	1	2	3
7. I lose things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. I am easily distracted by noises or other stimuli.	0	1	2	3
9. I am forgetful in daily activities.	0	1	2	3
10. I fidget and squirm a lot.	0	1	2	3
11. I have trouble remaining seated when it is expected.	0	1	2	3
12. I am restless and agitated	0	1	2	3
13. I have trouble engaging in leisurely activities quietly.	0	1	2	3
14. I am "on the go" and have a hard time relaxing.	0	1	2	3
15. I talk too much.	0	1	2	3
16. I blurt out answers before questions have been completed.	0	1	2	3
17. I have difficulty waiting my turn in conversations, activities or driving.	0	1	2	3
18. I interrupt or intrude in on others' conversations and/or activities.	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
19. I argue with others often.	0	1	2	3
20. I lose my temper easily.	0	1	2	3
21. I actively defy or refuse to go along with others' requests and/or activities.	0	1	2	3
22. I blame others for my mistakes or misbehavior.	0	1	2	3
23. I am touchy or easily annoyed by others.	0	1	2	3
24. I am angry or resentful.	0	1	2	3
25. I am spiteful and want to get even.	0	1	2	3
26. I have bullied, threatened, or intimidated others.	0	1	2	3
27. I start physical fights.	0	1	2	3
28. I lie to get out of trouble or to avoid obligations.	0	1	2	3
29. I am physically cruel to people.	0	1	2	3
30. I have stolen things that have value.	0	1	2	3
31. I have deliberately destroyed others' property.	0	1	2	3
32. I have used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
33. I have been physically cruel to animals.	0	1	2	3
34. I have deliberately set fires to cause damage.	0	1	2	3
35. I have broken into someone else's home, business, or car.	0	1	2	3
36. I have stayed out at night without informing others of my whereabouts.	0	1	2	3
37. I have left home overnight without warning.	0	1	2	3
38. I have forced someone into sexual activity.	0	1	2	3
39. I am fearful, anxious, or worried.	0	1	2	3
40. I am afraid to try new things for fear of making mistakes.	0	1	2	3
41. I feel worthless or inferior.	0	1	2	3
42. I blame myself for problems, feel guilty.	0	1	2	3
43. I feel lonely, unwanted, or unloved; complain that "no one loves me".	0	1	2	3
44. I am sad, unhappy, or depressed.	0	1	2	3
45. I am self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
46. Overall school/work performance	1	2	3	4	5
47. Reading	1	2	3	4	5
48. Math	1	2	3	4	5
49. Writing	1	2	3	4	5
50. Relationships with parents.	1	2	3	4	5
51. Relationships with siblings.	1	2	3	4	5
52. Relationships with peers.	1	2	3	4	5
53. Relationship with spouse/significant other	1	2	3	4	5

COMMENTS:

Provider Initials:_____

Children's MINNESOTA

Patient Health Questionnaire - PHQ 9

Instructions: How often have you been bothered by each of the following symptoms during the *last two weeks*? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling asleep or staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy?				
5. Poor appetite or overeating?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like reading the newspaper or watching television?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

FOR OFFICE CODING _____ + _____ + _____ + _____

=Total Score: _____

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Date completed: _____

PLACE PATIENT LABEL HERE

Source: PHQ-9(Author Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues)

Children's MINNESOTA | Partners in Pediatrics

PARENT or SIGNIFICANT OTHER REPORT
ADULT WORK/SCHOOL PROGRESS

Today's Date: _____ Name: _____ Date of Birth: _____

Parent/Significant Other Name: _____ Patient's Phone Number: _____

Directions: When completing this form, please think about the patient's behaviors in the past 6 months.

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Does not pay attention to details or makes careless mistakes with, for example, homework or other work.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms a lot.	0	1	2	3
11. Has trouble remaining seated when it is expected.	0	1	2	3
12. Is Agitated and restless	0	1	2	3
13. Has difficulty engaging in leisurely activities quietly.	0	1	2	3
14. Is "on the go" and has a hard time relaxing	0	1	2	3
15. Talks too much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn in conversations, activities, or driving.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues often.	0	1	2	3
20. Loses temper easily.	0	1	2	3
21. Actively defies or refuses to go along with others' requests and/or activities.	0	1	2	3
22. Blames others for his or her mistakes or misbehavior.	0	1	2	3
23. Is touchy or easily annoyed by others.	0	1	2	3
24. Is angry or resentful.	0	1	2	3
25. Is spiteful and wants to get even.	0	1	2	3
26. Bullies, threatens, or intimidates others.	0	1	2	3
27. Starts physical fights.	0	1	2	3
28. Lies to get out of trouble or to avoid obligations (i.e. "cons" others).	0	1	2	3
29. Is physically cruel to people.	0	1	2	3
30. Has stolen things that have value.	0	1	2	3
31. Deliberately destroys others' property.	0	1	2	3
32. Has used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Patient's Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
33. Is physically cruel to animals.	0	1	2	3
34. Has deliberately set fires to cause damage.	0	1	2	3
35. Has broken into someone else's home, business, or car.	0	1	2	3
36. Has stayed out at night without informing others.	0	1	2	3
37. Has left home overnight without warning.	0	1	2	3
38. Has forced someone into sexual activity.	0	1	2	3
39. Is fearful, anxious, or worried.	0	1	2	3
40. Is afraid to try new things for fear of making mistakes.	0	1	2	3
41. Feels worthless or inferior.	0	1	2	3
42. Blames self for problems, feels guilty.	0	1	2	3
43. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
44. Is sad, unhappy, or depressed.	0	1	2	3
45. Is self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
46. Overall school/work performance	1	2	3	4	5
47. Reading	1	2	3	4	5
48. Math	1	2	3	4	5
49. Writing	1	2	3	4	5
50. Relationships with parents.	1	2	3	4	5
51. Relationships with siblings.	1	2	3	4	5
52. Relationships with peers.	1	2	3	4	5
53. Relationship with spouse/significant other	1	2	3	4	5

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS**

❑ Brooklyn Park office
8500 Edinbrook Parkway
Brooklyn Park MN 55443
Phone: 763-425-1211
Fax: 612-874-2907

❑ Maple Grove office
12720 Bass Lake Road
Maple Grove MN 55369
Phone: 763-559-2861
Fax: 612-874-2902

❑ Plymouth office
2855 Campus Drive, #350
Plymouth MN 55441
Phone: 763-520-1200
Fax: 612-874-2908

❑ Rogers office
13980 Northdale Boulevard
Rogers MN 55374
Phone: 763-428-1920
Fax: 612-874-2916

❑ St. Louis Park office
3910 Excelsior Boulevard
St Louis Park MN 55416
Phone: 952-562-8787
Fax: 612-874-2909

Provider Initials:_____