West Elgin Community Health Centre

Child & Youth History Form Applicant Name: _____

Person Completing form: _____ Relationship to child/Youth: _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Immunization Record – Please list below with dates or provide copy of immunization record

IMMUNIZATION	DATES				
DTap-IPV-Hib (Diphtheria, Tetanus, Pertussis, Polio, H Influenza)					
Pneu-C-13 - Pneumococcal Conjugate 13					
Rot-1 - Rotavirus					
Men-C-C - Meningococcal Conjugate C					
MMR - Measles, Mumps, Rubella					
Var - varicella					
MMRV - Measles, Mumps, Rubella, Varicella					
Tdap-IPV - Tetanus, diphtheria, pertussis, Polio					
HB - Hepatitis B					
Men-C-ACYW - Meningococcal Conjugate ACYW-135					
Tdap - Tetanus, diphtheria, pertussis					
HPV					
Men-C-ACYW					

Health and Development History

Describe any difficulties or serious illnesses at birth, if any:

_____

_____

_____

Describe your child's general health (e.g. recurrent colds, ear infections, stomach aches, etc)

_____

_____

_____

How would you describe your child's emotional, physical, and social growth and development to this point:

_____

_____

_____

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Child & Youth History Form **Applicant Name:** _____

Are there presently any serious medical problems (circle)? ☐ NO ☐ YES If yes, list & describe:

_____

_____

_____

_____

Is the child involved with any other specialist/service (CAS) /counselor? Please list below.

Who: _____ When Last seen: _____

Why: _____

Who: _____ When Last seen: _____

Why: _____

Who: _____ When Last seen: _____

Why: _____

Who: _____ When Last seen: _____

Why: _____

Medication	Dose (e.g. mg/pill)	# times/day	Why taking?

Allergies to foods, medications, contact allergies, etc. - circle? ☐ NO ☐ YES If yes, please list:

Allergen	Type of Reaction

Tobacco Use: Has child ever smoked cigarettes: □ No □ Yes Still smoking? □ No □ Yes If child smoked and has quit, list quit date: _____ If quit, how many years did child smoke: _____ If quit, # packs/day did child smoke: _____ **Current Smoker:** Packs/day _____ # of years _____	**Exercise:** Does child exercise regularly? Yes No What kind of exercise? _____ _____ _____ How long does child exercise (minutes) _____ How Often? _____
Alcohol Use: Does child drink alcohol? No Yes # of drinks/week _____ Beer Wine Liquor	**Diet:** How would you rate child's nutrition? Good Fair Poor Would you like advice on child's diet? Yes No
Drug Use: Does child use marijuana/recreational drugs: Yes No Has child ever used needles to inject drugs: Yes No	

SOCIAL HISTORY, GOALS AND SUPPORTS:

This information helps us to better understand who you are, your strengths and your support systems. It will also help to identify your beliefs, values and cultural preferences so that we can incorporate them into your care where possible. If not applicable to child please enter N/A.

Occupation: _____

Employer: _____

Marital status (circle one): Single Partner Married Divorced Widowed

Spouse/partner's name: _____

Number of children: _____ Ages if under 18 years: _____

Do you live alone? _____ If not alone, who lives with you? _____

Do you have access to transportation for appointments/programs/personal needs? _____

State any specific transportation requests/needs: _____

Do you require forms/communication in a language other than English? If yes, what language? _____

Do you require a translator? ☐ NO ☐ YES If yes, do you have access to a translator to assist you? ☐ NO ☐ YES

State any specific requests for translator: _____

Please identify any cultural/religious preferences/needs that you would like us to know about so we can incorporate them into your child's care:

_____

_____

Please list any specific goals you would like to work on with your child's care team? _____

_____

_____

Do you have access to sufficient funds/benefits/financial aid to cover costs of meds etc.? ☐ NO ☐ YES

If no, please explain: _____

_____

_____

Are you receiving ODSP/Ontario Works or other form of financial support to assist you? ☐ NO ☐ YES

Please list: _____

OTHER SUPPORTS:

Is the child involved with any other specialist/service/CAS/counselor? State name/why seeing/when last seen

Who: _____ When Last seen: _____

WHY _____

Who: _____ When Last seen: _____

WHY _____

Who: _____ When Last seen: _____

WHY _____

Please identify any cultural/religious preferences/needs that you would like us to know about so we can incorporate them into your care:

_____

_____

_____

Please list any specific goals you would like to work on with your care team:

_____

_____

_____

Legal Guardian:

Who has legal guardianship to make child's medical decisions (list all)? List names and contact info below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

If you have legally appointed a Power of Attorney for Personal Care (PAPC) to make health care decisions on your behalf if you became unable to do so, please list their contact information below. If you do not have a PAPC, the law lists who the person would be in order of position (e.g. spouse, parent, child, sibling etc.).

Name: _____ Relationship: _____ Phone: _____

If you have a written Advanced Care Plan, please provide us with a copy for your file.

We know that having conversations about your care wishes can often be difficult. To help to ensure that decisions made on your behalf are in keeping with your beliefs and values, we suggest that everyone, no matter your age or health status, talk about your wishes with your family/substitute decisions makers.

Please list below, anything else you feel it would be helpful for us to know.

_____

_____

_____

Person completing form: _____ Relationship: _____

Signature: _____ Date: _____

The information on this form will be used to build your child's chart. It is also used to help us divide applicants among our providers so each provider has similar numbers of complex clients to care for.
We invite all applicants for an intake appointment.
At this appointment, we share what the centre offers, review the application and discuss client care needs and expectations. At the end of the intake, if you decide you wish to be a client with us, we will have you sign some forms regarding your privacy etc. The intake appointment is a meet and greet.
We will not be completing forms, writing prescriptions etc. at this appointment.

Thank-you for taking the time to fill this out