River Oak
Center for Children

CHILD/YOUTH HEALTH AND NUTRITION QUESTIONNAIRE

Today's Date: Staff:

Parent/Caregiver Name: Relationship to Client: Phone #:

Person Completing the Form: Relationship to Client: Phone #:

Child/Youth's Primary Care Physician:

Name: Phone #

Address: City: State: Zip:

MEDICATION(S) CHILD/YOUTH IS TAKING OR HAS TAKEN

(Please list ***ALL*** current and past medications including ***over the counter*** drugs, ***alternative*** drugs, ***psychotropic*** and ***non-psychiatric*** medications).

Start Date	Stop Date	Medication	Strength	Directions	Prescribed By	Effective Yes/No	Comments

Have you had positive experiences with psychotropic medications? YES ☐ NO ☐ N/A ☐
Please explain:

Have you ever had negative experiences with psychotropic medications? YES ☐ NO ☐ N/A ☐
Please explain:

Has your child experienced any medication side effects or allergies? YES ☐ NO ☐ N/A ☐
Please explain:

Any additional comments about medications:

MOTHERS'S PREGNANCY HISTORY ☐ Pregnancy History Unknown

Length of Pregnancy: ____Months ____Weeks

Circumstances surrounding pregnancy: ☐ Planned ☐ Unplanned ☐ Unknown

Trimester prenatal care was started: 1st ☐ 2nd ☐ 3rd ☐ None ☐ Mother's age at beginning of pregnancy: _____

Comments on mother's pregnancy planning:

MOTHER'S HEALTH DURING PREGNANCY (Please check those that apply and explain.)

Mother's Health During Pregnancy Unknown ☐

Condition	Please ☑	Comments/Explanation
Anemia	Yes ☐ No ☐ Unk ☐	
Bleeding	Yes ☐ No ☐ Unk ☐	
Edema (Swelling)	Yes ☐ No ☐ Unk ☐	
Elevated Blood Pressure	Yes ☐ No ☐ Unk ☐	
Vomiting	Yes ☐ No ☐ Unk ☐	
German Measles	Yes ☐ No ☐ Unk ☐	
Chronic Illness	Yes ☐ No ☐ Unk ☐	
Injuries	Yes ☐ No ☐ Unk ☐	
Emotional Challenges or Trauma	Yes ☐ No ☐ Unk ☐	
STDs	Yes ☐ No ☐ Unk ☐	
Prescribed Medications	Yes ☐ No ☐ Unk ☐	
Use of Over-the-Counter Drugs	Yes ☐ No ☐ Unk ☐	
Use of Tobacco Products	Yes ☐ No ☐ Unk ☐	
Use of Alcohol (Specify Frequency)	Yes ☐ No ☐ Unk ☐	
Use of Drugs	Yes ☐ No ☐ Unk ☐	
Other Illness	Yes ☐ No ☐ Unk ☐	

LABOR/DELIVERY HISTORY

Labor/Delivery History Unknown ☐

Duration of Labor Hours:	Anesthesia Used? Yes ☐ No ☐
Medications Used:	Birth Weight: lbs. Oz. Length:
Number of Days Mother was in the Hospital:	Number of Days Child was in the Hospital:
Breast Fed? Yes ☐ No ☐ If yes, how long?	
Name of Hospital Child was Born:	Address of Hospital:

Where there any difficulties or peculiarities in child's appearance or behavior at birth or during infancy? Yes ☐ No ☐
Please Explain:

BIRTHING COMPLICATIONS (Please check those that apply and explain)

Birthing Complications Yes ☐ No ☐ Unknown ☐

Circumstance	Please ☑	Comments/Explanation
Infections	Yes ☐ No ☐ Unk ☐	
Cord Around Neck	Yes ☐ No ☐ Unk ☐	
Forceps Delivery	Yes ☐ No ☐ Unk ☐	
Multiple Birth	Yes ☐ No ☐ Unk ☐	
Breathing Problems	Yes ☐ No ☐ Unk ☐	
Hemorrhage	Yes ☐ No ☐ Unk ☐	
Breech Birth	Yes ☐ No ☐ Unk ☐	

Caesarean Delivery	Yes ☐ No ☐ Unk ☐	
Premature Separation of Placenta	Yes ☐ No ☐ Unk ☐	
Fetal Distress	Yes ☐ No ☐ Unk ☐	
Premature at Birth	Yes ☐ No ☐ Unk ☐	

NEONATE HISTORY (Day 1 through Day 30) (Please check those that apply and explain)

Neonatal History Unknown ☐

Circumstance	**Please ☑**	**Comments/Explanation**
Cyanosis (blue baby)	Yes ☐ No ☐ Unk ☐	
Jaundice (yellow baby)	Yes ☐ No ☐ Unk ☐	
Paralysis (cannot move)	Yes ☐ No ☐ Unk ☐	
Listless Baby	Yes ☐ No ☐ Unk ☐	
Convulsions	Yes ☐ No ☐ Unk ☐	
Drug Withdrawal (jitteriness)	Yes ☐ No ☐ Unk ☐	
Oxygen Needed for Baby	Yes ☐ No ☐ Unk ☐	
Exchange Transfusion	Yes ☐ No ☐ Unk ☐	
Feeding Difficulties	Yes ☐ No ☐ Unk ☐	
Problems with Elimination (i.e. constipation)	Yes ☐ No ☐ Unk ☐	
Neo-Natal Intensive Care Unit?	Yes ☐ No ☐ Unk ☐	
Other	Yes ☐ No ☐ Unk ☐	

DEVELOPMENTAL HISTORY (Explain if necessary)

Developmental History Unknown ☐

Question	**Age**	**Mos /yr.**	**Explanation**	**Question**	**Age**	**Mos/yr.**	**Explanation**
Age held head up?				Age walked?			
Age turned over?				Age used sentences?			
Age sat up?				Age weaned?			
Age crawled?				Age dressed self?			
Age used single word?				Age bowel trained?			
Age fed self?				Age dry through the night?			

Is your child meeting developmental milestones? Yes ☐ No ☐ Unk ☐

CONDITIONS/BEHAVIORS – (Explain if necessary)

Descriptor	**Please ☑**	**Age**	**Mos /Yrs.**	**Comments/Explanation**
Headaches/Migraines	YES ☐ NO ☐ UNK ☐			
Seizures (convulsions, epilepsy)	YES ☐ NO ☐ UNK ☐			
Meningitis/Encephalitis	YES ☐ NO ☐ UNK ☐			
High fever	YES ☐ NO ☐ UNK ☐			
Weight Problems (weight change of 10 lbs. in the last 3 months)	YES ☐ NO ☐ UNK ☐			
Thyroid Problem	YES ☐ NO ☐ UNK ☐			
Nutritional Intake Concerns	YES ☐ NO ☐ UNK ☐			
Lack of Growth	YES ☐ NO ☐ UNK ☐			
Special Diet/Food Allergies	YES ☐ NO ☐ UNK ☐			
Binging/Purging/Refusing or Restricting Food Intake	YES ☐ NO ☐ UNK ☐			
Stomach Aches (chronic)	YES ☐ NO ☐ UNK ☐			

Descriptor	Please ☑	Age	Mos /Yrs.	Comments/Explanation
Diarrhea/Constipation	YES ☐ NO ☐ UNK ☐			
Chronic Vomiting/Swallowing /Chewing or Digestion Concerns	YES ☐ NO ☐ UNK ☐			
Enuresis (involuntary urination)	YES ☐ NO ☐ UNK ☐			
Encopresis (involuntary discharge of feces)	YES ☐ NO ☐ UNK ☐			
Diabetic	YES ☐ NO ☐ UNK ☐			
Failure to Thrive	YES ☐ NO ☐ UNK ☐			
Head Injury or Concussion	YES ☐ NO ☐ UNK ☐			
Hepatitis	YES ☐ NO ☐ UNK ☐			
Birth Defect	YES ☐ NO ☐ UNK ☐			
Skin Problems (eczema, rashes, etc.)	YES ☐ NO ☐ UNK ☐			
Health Concerns that Limit Activity	YES ☐ NO ☐ UNK ☐			
Smoke/Chew Tobacco	YES ☐ NO ☐ UNK ☐			
Arthritis	YES ☐ NO ☐ UNK ☐			
Carpal Tunnel Syndrome	YES ☐ NO ☐ UNK ☐			
Osteoporosis	YES ☐ NO ☐ UNK ☐			
Heart Problems (murmur, heart defect)	YES ☐ NO ☐ UNK ☐			
Fainting Spells/Loss of Consciousness	YES ☐ NO ☐ UNK ☐			
Chest Pain, Breathing Difficulty, Asthma	YES ☐ NO ☐ UNK ☐			
Ulcers	YES ☐ NO ☐ UNK ☐			
Obesity	YES ☐ NO ☐ UNK ☐			
Anemia	YES ☐ NO ☐ UNK ☐			
Allergies	YES ☐ NO ☐ UNK ☐			
Cancer	YES ☐ NO ☐ UNK ☐			
Chronic Pain	YES ☐ NO ☐ UNK ☐			
Cirrhosis	YES ☐ NO ☐ UNK ☐			
Multiple Sclerosis	YES ☐ NO ☐ UNK ☐			
Muscular Dystrophy	YES ☐ NO ☐ UNK ☐			
Physical Disability	YES ☐ NO ☐ UNK ☐			
Tinnitus	YES ☐ NO ☐ UNK ☐			
Ear Infections	YES ☐ NO ☐ UNK ☐			
Sexually Transmitted Diseases (STD)	YES ☐ NO ☐ UNK ☐			
Hyperlipidemia	YES ☐ NO ☐ UNK ☐			
Hypercholesterolemia	YES ☐ NO ☐ UNK ☐			
Hypertension	YES ☐ NO ☐ UNK ☐			
Cystic Fibrosis	YES ☐ NO ☐ UNK ☐			
Digestive Disorders (reflux, irritable bowel syndrome)	YES ☐ NO ☐ UNK ☐			
Other Medical Condition	YES ☐ NO ☐ UNK ☐			
Unknown/ Not Reported general Medication Condition	YES ☐ NO ☐ UNK ☐			

CHILD/YOUTH'S MEDICAL HISTORY

Date of last physical examination: By Whom?

How long has it been since the last physical examination?

Current height - Feet: Inches: Current weight: lbs.

Do you have any concerns about your child/youth's growth? Yes ☐ No ☐ (If yes please explain):

Are there health condition(s) your child/youth is receiving treatment for? Yes ☐ No ☐

Are child/youth's immunizations up to date? Yes ☐ No ☐ (Please explain):

Has child/youth ever been in an auto accident or experienced any type of head injury or trauma? YES ☐ NO☐ (Please explain):

Has child/youth ever had broken bones? YES ☐ NO ☐ (Please explain):

Is child/youth prone to accidents? YES ☐ NO ☐ (Please explain):

Has child/youth ever had episodes of easy bruising or bleeding? YES ☐ NO ☐ (Please explain):

EYE/VISION HISTORY

Does child/youth have any visual problems? YES ☐ NO ☐
Please explain:
Date of last eye exam?
When was the last vision exam?
Does Child/youth wear glasses or contacts? YES ☐ NO☐

HEARING

Does child/youth have a hearing problem? YES ☐ NO ☐
Please explain:
Has child/youth had an ear injury? YES ☐ NO ☐
Please explain:
Has child/youth had a hearing test? YES ☐ NO ☐
If yes, what are the results?
Does child/youth have tubes in their ears? YES ☐ NO ☐
Does child/youth wear hearing aids? YES ☐ NO ☐
Does child/youth have chronic ear infections? YES ☐ NO ☐

DENTAL HISTORY

Has the child/youth ever visited a dentist? YES ☐ NO ☐
When was your child/youth's last visit to the dentist?
Has the child/youth ever undergone oral surgery? (extractions) YES ☐ NO ☐
Does the child have any dental problems? (cavities, orthodontics, traumatic injuries, & occlusion, other) YES ☐ NO ☐
Please explain:

FAMILY MEDICAL HISTORY Family Medical Conditions Unknown ☐

Condition	Please ☑	Explanation
Weight Problems	Yes ☐ No ☐ Unk ☐	
Heart Disease/Heart Attacks	Yes ☐ No ☐ Unk ☐	
Stroke	Yes ☐ No ☐ Unk ☐	
Thyroid Disease	Yes ☐ No ☐ Unk ☐	
Diabetes	Yes ☐ No ☐ Unk ☐	
Other	Yes ☐ No ☐ Unk ☐	

MEDICAL HOSPITALIZATION

Has child/youth ever required hospitalization? YES ☐ NO ☐

Reason(s) for hospitalization (Please provide the dates of hospitalization):

Operations (Please describe):

Name and Address of hospital(s):

Has the child/youth ever been to the emergency room? YES ☐ NO ☐
Please explain (include dates):

****Are there other health issues or concerns, history of serious injury, trauma, health problems or health information that we need to be made aware of or needs to be discussed with your clinician? Yes ☐ No ☐ Unknown ☐ If yes or unknown, please explain:**

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- If any items indicate a yes for a condition or behavior that is **not** under current medical care or has previously **not** been treated by a Health Care Professional and/or if the client has **not** had a physical exam in the past year; you must have a discussion with the family about the importance of accessing quality health care and your decision to refer or not refer the client to a Primary Care Physician for health care services.

  Referral needed for: ☐ Nutrition Consultation ☐ Physical Exam ☐ Dental Exam ☐ Vision Exam

- All identified physical or nutritional condition(s)/behavior(s) must be documented in a Progress Note and if a "referral" or "linkage" to a Healthcare Provider(s) was or was not made and why.
- If any significant amount of information is **"Unknown"** Please explain rationale and what "good-faith" measures were taken to gather the information.

Please identify the Date of the Progress Note: _____.
Date

The Health and Nutrition Questionnaire (HNQ) must be completed within 45 days of Provider Start Date and an update is completed annually with a request for re-authorization, as well as in conjunction with any transfer. The HNQ update may be completed upon a re-opening to the system if the last HNQ has been completed within the last 6 months.

THIS FORM CONTAINS CONFIDENTIAL CLIENT INFORMATION (Please see W&I Code 5328)

_____Today's Date:_____
Staff Signature (I have reviewed this document with the caregiver and child/youth)

Print Name:_____Classificaton:_____Staff ID #_____

Protocol: Business support will mail a referral letter if needed and a copy of the referral letter will be given to HIM to be scanned into the child/youth's chart.