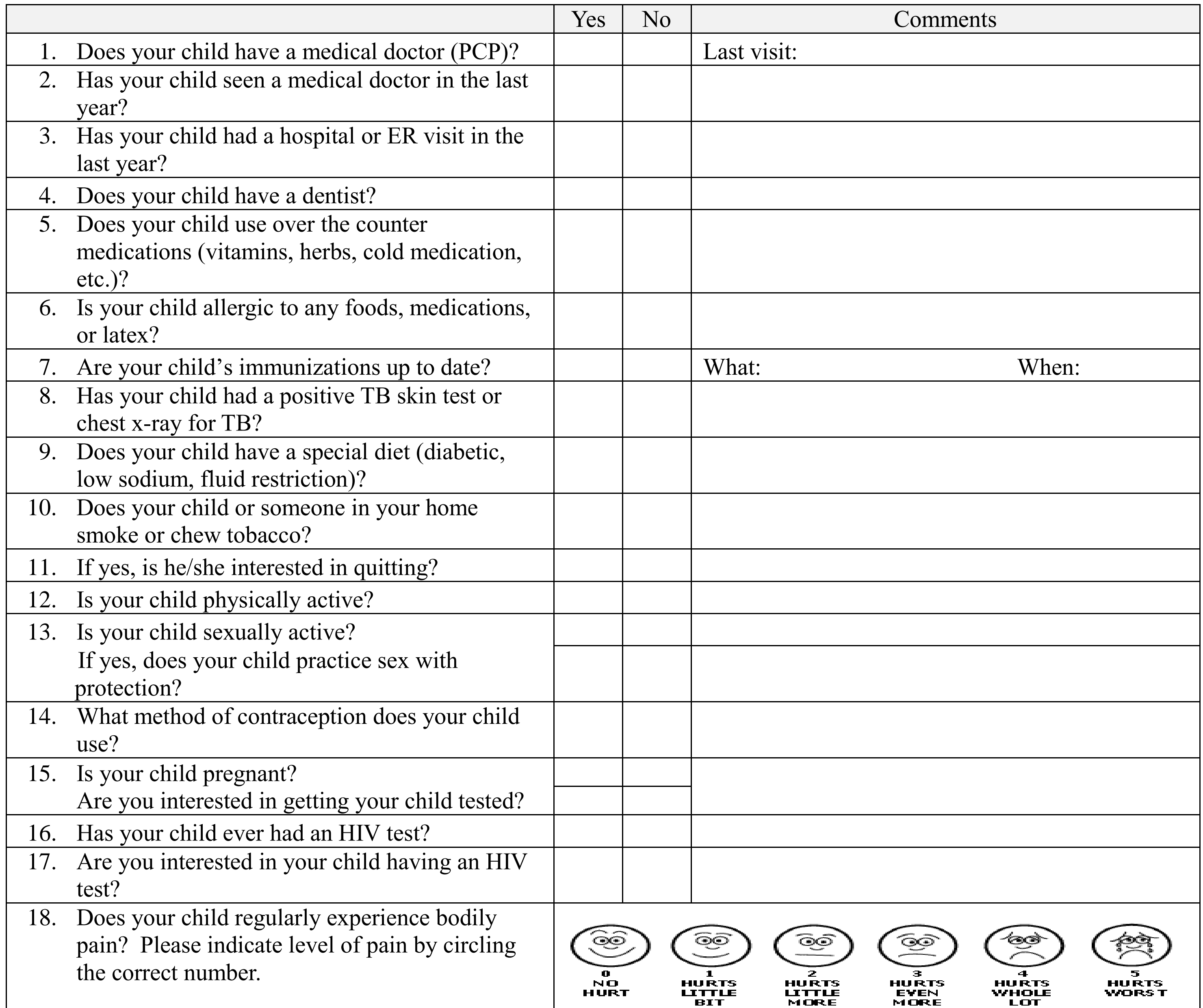
Attachment B: Capital Area Human Service District
Child Physical Health Questionnaire

Name: ____ Date: ____________
Date of Birth: ____________________ Race: ____________________ Sex: _________
Health Insurance: Medicaid: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No Other: ☐ Yes ☐ No
If yes, please provide number: ____



	Yes	No	Comments
1. Does your child have a medical doctor (PCP)?			Last visit:
2. Has your child seen a medical doctor in the last year?			
3. Has your child had a hospital or ER visit in the last year?			
4. Does your child have a dentist?			
5. Does your child use over the counter medications (vitamins, herbs, cold medication, etc.)?			
6. Is your child allergic to any foods, medications, or latex?			
7. Are your child's immunizations up to date?			What: When:
8. Has your child had a positive TB skin test or chest x-ray for TB?			
9. Does your child have a special diet (diabetic, low sodium, fluid restriction)?			
10. Does your child or someone in your home smoke or chew tobacco?			
11. If yes, is he/she interested in quitting?			
12. Is your child physically active?			
13. Is your child sexually active?			
If yes, does your child practice sex with protection?			
14. What method of contraception does your child use?			
15. Is your child pregnant?			
Are you interested in getting your child tested?			
16. Has your child ever had an HIV test?			
17. Are you interested in your child having an HIV test?			
18. Does your child regularly experience bodily pain? Please indicate level of pain by circling the correct number.	0 NO HURT / 1 HURTS LITTLE BIT / 2 HURTS LITTLE MORE / 3 HURTS EVEN MORE / 4 HURTS WHOLE LOT / 5 HURTS WORST		

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19. Please (✓) check any of the following that apply to your child:

		Comment			Comment
	Head injury			Mouth/ teeth problems	
	Frequent headaches			Stomach pain/ upset	
	Dizzy/ frequent falling			Recent weight gain/ loss	
	Seizures			Constipation	
	Confused/ forgetful			Rectal bleeding	
	Shaking/ trembling			Painful/ difficulty urinating	
	Eye/vision problems			Bedwetting	
	Poor hearing			Sleep problems	
	Frequent cold/ coughing			Mood changes	
	Wheezing/ shortness of breath			Muscle stiffness/ muscle pain	
	Cardiac problems/ chest pain				
	High blood pressure				
	Thyroid problems			Pap Smear date:	
	Diabetes			Positive TB test:	
	Weak/ tired all the time				
	Bruise easily/ anemia				

Client/Guardian Signature: ______________________________ Date: __________

Client Representative Signature: ______________________________ Date: __________
(If applicable)

For CAHSD Staff Use Only

☐ Physical health screening information reviewed with client ☐ Release of information for PCP/Clinic signed
☐ Referrals reviewed with client

Referral to:

☐ Primary Care Provider Name: ______________________________

Reason for visit: ______________________________

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☐ Other: ______________________________

Nurse (Print): ______________ Signature: ______________ Date: __________

Physician (Print): ______________ Signature: ______________ Date: __________

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