

HEALTH QUESTIONNAIRE-Part 1

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Name of Client: _____

Name of Person Completing Questionnaire: _____

Relationship to Client: _____

How was the client's mother's health during pregnancy?

___ Good ___ Fair ___ Poor ___ Don't Know

How old was the client's mother when he/she was born?

___ Under 20 ___ 20-24 ___ 25-29 ___ 30-34 ___ 35-39 ___ 40-44 ___ Don't Know

Did the client's mother ever use any of the following during pregnancy?

Beer or Wine ___ No ___ Yes How many times: _____

Hard Liquor ___ No ___ Yes How many times: _____

Coffee or caffeinated products ___ No ___ Yes How many times: _____

Prescription medications ___ No ___ Yes What and how many times: _____

Were there any complications during the client's mother's pregnancy?

___ Toxemia ___ Eclampsia ___ Rh factor incompatibility ___ Emotional Hardships ___ Don't Know

Was the client born: ___ 8 months or earlier ___ Full Term ___ Don't Know

Was the delivery: ___ Normal ___ Breech ___ Caesarian ___ Forceps ___ Induced

Client's weight at birth: _____

Were there any complications following the birth? ___ No ___ Yes Please explain: _____

Did the client experience any of the following problems in infancy?

Colic ___ No ___ Yes Sleep difficulties ___ No ___ Yes

Alertness ___ No ___ Yes Feeding problems ___ No ___ Yes

Please explain any "yes" answers:

Did the client have any hospitalizations or health problems in infancy or as a toddler? Please explain.

Was the client ever diagnosed as failure to thrive? No Yes

Please explain: _____

At what age did the client: sit up _____ crawl _____
walk _____ speak single words (other than mama or dada) _____
string two or more words together _____

At what age was the client toilet trained? _____ How long did it take? _____

Are there any problems with the client's: vision hearing
 gross or fine motor coordination speech/articulation

Does the client have any chronic health problems (asthma, heart condition, etc.?) Please explain and give age when problems began: _____

Which of the following illnesses has the client had?

pneumonia ear infections lead poisoning seizures other (please explain)

Has the child had any injuries? No Yes Please explain: _____

Is the client accident prone? No Yes

Has the client ever had surgery for the following: tonsillitis adenoids hernia appendicitis
 eye, ear, nose, and/or throat digestive tract appendix burns
 other (please explain) _____

Does the client often complain of physical discomforts, such as headache, stomachache, nausea, etc.

___ No ___ Yes Please explain and include duration of complaints: _____

Do you suspect or know if the client uses drugs or alcohol? ___ No ___ Yes What drugs: _____

Does the client currently have any sleep difficulties, such as difficulty falling asleep, staying asleep, or early morning awakening? _____

Does the client have any bladder or bowel control problems during the night? ___ No ___ Yes

How often? _____

What is the client's normal appetite? ___ overeats ___ average ___ undereats

VERIFICATION OF IMMUNIZATIONS:

DTP/TD (Diphtheria-Tetanus-Pertussis)

Month & Year:

- 1.
- 2.
- 3.
- 4.
- 5.

ORAL POLIO

Month & Year:

- 1.
- 2.
- 3.
- 4.

MMR

Month & Year:

- 1.
- 2.

TETANUS BOOSTER

Month & Year:

- 1.

HIB

Month & Year:

- 1.
- 2.
- 3.

Hepatitis B

Month & Year:

- 1.
- 2.
- 3.

Please indicate date of illness or vaccination if not noted above:

_____ chicken pox _____ measles _____ mumps

Date Health Questionnaire Completed: _____

Signature