The Mid-Florida Center, Inc.

COX BEHAVIORAL HEALTH GROUP LLC

YOUTH MEDICAL HISTORY

Name:		
Parent / Caregiver or Emergency Contact:		
Phone Number of Emergency Contact:		
Phone Number:	Email Address:	
Date of Birth:	Age:	Gender:

SECTION A – CURRENT MEDICAL

Please describe any physical health issues for which the youth is currently under the care of a physician?	
Physician's Name:	
Address:	Phone:
If there are any other medical personnel involved with this youth, please list:	
What hospital is the youth taken to for medical services?	
Please list all prescription and non-prescription medications taken on a regular basis:	
medication:	reason:
medication:	reason:
medication:	reason:

SECTION B – MEDICAL HISTORY
Please check any conditions that apply and describe.

	routine childhood illnesses (i.e. Chicken Pox, Measles)	age/year:
	respiratory problems (i.e. asthma)	age/year:
	cardiovascular problems (i.e. heart conditions)	age/year:
	gastrointestinal (i.e. stomach ulcers)	age/year:
	eating disorders (i.e. anorexia, bulimia)	age/year:
	musculoskeletal (i.e. muscle, bone, joint problems)	age/year:
	neurological (i.e. seizures)	age/year:
	liver or kidney	age/year:
	tuberculosis	age/year:
	hepatitis	age/year:
	cancer	age/year:
	allergies: (please list)	

SECTION B – MEDICAL HISTORY (continued)		
	sexually transmitted diseases	age/year:
	immune disorders (i.e. HIV/AIDS)	age/year:
NOTE: Disclosure of HIV status is optional; such disclosure will be regarded as super-confidential and information will not be re-disclosed without specific written consent of the person served.		
	stress-related medical problems (i.e. chronic headaches, stomachaches)	age/year:
	developmental problems	age/year:
	learning disabilities / intellectual impairments	age/year:
	speech, hearing or vision problems	age/year:
Please describe any delays in the youth's developmental or grade level in school?		
Prior hospitalizations for injuries, illnesses, surgeries, etc.:		
Prior significant head injuries or periods of unconsciousness or coma:		
Has the youth received all required immunizations? y n If no, please provide details:		
How many days of school has the youth missed in the current marking period due to illness?		
Please describe any other medical conditions not identified above?		
Please describe any conditions that would prevent this youth from self-preservation in the case of an emergency:		
SECTION C – FOR GIRLS ONLY		
At what age did the youth begin regular menstrual cycles? Describe any problems she is having currently with her menstrual cycle?		
If the youth is currently pregnant, how many weeks? _____ not pregnant _____ weeks pregnant		
Describe any currently problems this youth is having with a pregnancy or the post-partum phase of pregnancy?		

I certify that the information provided is true and accurate to the best of my knowledge. I understand that the information with be utilized by the Cox Behavioral Health Group LLC for the purpose of conducting a comprehensive assessment and evaluation of my child's need for mental health or substance abuse services. I further certify that, to the best of my knowledge, my child is capable of self-preservation in the event of an emergency and if he/she had impairments that interfere with self-preservation, I would make these known.

_____ _____

parent/caregiver signature date

FOR OFFICE USE ONLY

☐ no medical concerns that warrant referral	☐ medical conditions warrant a referral
☐ the parent was recommended to follow-up with medical services and/or a referral was made to:	

_____ _____

staff signature date