



Rimrock Trails Adolescent Treatment Services
www.rimrocktrailsats.com
 Residential & Outpatient Main Campus: 1333 NW 9th St., Prineville, OR 97754 – (541)447-2631
 Redmond Outpatient Office: 413 SW 8th St., Redmond, OR 97756 – (541)617-4771
 Bend Outpatient Office: 63360 Britta St. Bldg. #1, Bend, OR 97701 (541)388-8459
 Toll Free: 1-888-532-6237

Medical History Questionnaire

Date: _____
 Client's Name: _____ Age: _____
 Allergies (list): _____
 Primary care physician: _____ Date of last complete physical: _____
 Reason for last doctor visit: _____
 Do you currently take any medications? _____yes _____no

Name of Medication	Strength	How Often	Physician

Client Responses

Recent changes in weight? _____ Comfortable with weight? _____
 Have you ever made yourself vomit, used laxatives (purged) after eating? _____
 Ever diagnosed with an eating disorder? Yes No If Yes, please explain: _____
For Women Only: Are you pregnant? Yes No If Yes, when is your due date? _____
 Are you concerned you might be pregnant? Yes No
 How do you feel about your pregnancy? _____
 What substances have you used during your current pregnancy? _____
 Any history of pregnancy? Yes No If Yes, please explain: _____

Medical History Continued

How many times have you been pregnant? _____ How many births? _____

How many children do you have?

Date of Last menstrual cycle: _____

Sexually Active? Yes No

How many sexual partners? _____

Have you had unprotected sex? _____

Have you had unprotected sex with someone who was using? _____

Are you an injection drug user? yes no? When last use? _____

If yes, referred to physician for exam with _____ telephone: _____

**Parent/Guardian or Client
Developmental Milestones:**

Childbirth- Full Term yes no
Normal Weight yes no
Growth Milestones On Time yes no
Pre-birth exposure to drugs or alcohol (including tobacco) yes no what type: _____
Any major illnesses, injuries, hospitalizations yes no
Any re-occurring medical problems or infectious diseases, chronic health problems or disabilities yes no
If yes explain: _____

Is a family member/caregiver experiencing any medical issues? Yes No Explain: _____

Were there any problems/complications during mother's pregnancy, labor or birth? _____

Motor Development

*Age: Sitting _____ Crawling _____ Walking _____

*Age: Riding Trike/Bike _____

*Any trouble throwing/catching a ball? Drawing or coloring? y n If yes, explain _____

*Unusually Clumsy? y n if yes, explain _____

Social Adaptive Skills

*Age: Toilet Trained (day, night)

*Problems with enuresis or encopresis? y n if yes, explain _____

*Age dressed self/tied shoe _____

* Behavior, attention span, conduct, activity level (childhood)? _____

* Peer relations (childhood)? _____

Speech and Language Development

*Age: Babbling _____ Cooing _____

*Age: Single words _____ Phrases _____

*Age: Understands direction and converses _____

Medical History Continued

Temperament throughout development? Easy Difficult Shy/slow to warm up
Explain _____

Smoking cessation information given to client? Will be part of current treatment episode.

HIV/Infectious Disease Risk Assessment Completed:

Any other medical conditions or concerns that you feel Rimrock Trails ATS needs to be aware of:

Client Signature

Date

Parent/Guardian Signature

Date

Outpatient Counselor

Date

Staff Notes _____

