



Rimrock Trails Adolescent Treatment Services
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 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: 1010 NW 14th St, 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? _____

Revised 1/06/09

Federal regulations (42CFR, Part 2) prohibits you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.

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 _____

Do you have problems with the following:

Eyes, ears, nose, throat _____yes _____no Last Eye Exam: _____

Skin Infections _____yes _____no

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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
