



**Rimrock Trails Adolescent Treatment Services**  
[www.rimrocktrailsats.com](http://www.rimrocktrailsats.com)  
 Residential & Outpatient Main Campus: 1333 NW 9<sup>th</sup> St., Prineville, OR 97754 – (541)447-2631  
 Redmond Outpatient Office: 413 SW 8<sup>th</sup> St., Redmond, OR 97756 – (541)617-4771  
 Bend Outpatient Office: 1010 NW 14<sup>th</sup> 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

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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:

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\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Admission Director**

\_\_\_\_\_  
**Date**

**Staff Notes**

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