# PEDIATRIC HEALTH HISTORY FORM

| Child/Adolescent Name | Birth Date | Age | Gender | Grade | School/Teacher |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | Mailing Address (PO Box) | City | Zip Code | Email |
|---|---|---|---|---|
| | | | | |

Race (Optional) ❒ White ❒ Black ❒Asian ❒American Indian ❒ More Than One ❒ Other

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒Hispanic ❒Arabic

| Mother/Parent Name | Mother/Parent Birth Date | | Phone Number |
|---|---|---|---|
| | | | |

| Father/Parent Name | Father/Parent Birth Date | | Phone Number |
|---|---|---|---|
| | | | |

| Preferred Telephone Number | May We Leave a Message? Yes No | Best Time of Day to Be Contacted? |
|---|---|---|
| | | |

| Guardian Last Name (if different than mother/father) | Guardian First Name | Guardian Telephone Number | Relationship To Student |
|---|---|---|---|
| | | | |

| Name of Emergency Contact (other than parent/guardian) | Relationship | Telephone Number |
|---|---|---|
| | | |

| Name of Student's Physician or Clinic | Physician or Clinic Telephone Number | |
|---|---|---|
| | | |

## HEALTH INSURANCE (Please complete all information)

❒ None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child. ❒ Yes ❒ No

❒ Medicaid/Medicaid HMO Child's Card Number _____

❒ Blue Cross/Blue Shield
❒ Blue Care Network
❒ Priority Health
❒ TriCare
❒ Other:_____

Name of Policy Holder
_____

Insurance Policy Number
_____

Insurance Group Number
_____

Birth Date of Policy Holder
_____

Relationship of Policy Holder to child?
_____

Does your insurance pay for immunizations? ❒ Yes ❒ No

alcona citizens for health, inc.
dba
AHC alcona health centers
"Your family health center"

# BEHAVIORAL HEALTH TREATMENT CONSENT FORM

**Alcona Health Centers (AHC) is offering Behavioral Health Services (BHS) at Sheridan Elementary School. These services will be provided by Elise Tippett, LMSW, a State of Michigan licensed Clinical Social Worker employed by AHC as a behavioral health therapist. As a condition for offering these services to your child, AHC is requiring that a parent or legal guardian must give written, informed consent, as outlined below. This consent may be revoked at any time.**

**As the parent or legal guardian of _____ DOB:_____**

1. **I understand that BHS will include a behavioral health assessment of my child, during which I may be asked to provide information about my child's emotional needs and behavior at home and school. I may be invited to be actively involved in the treatment planning for my child. My acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.**
2. **I understand that Elise Tippett, LMSW maintains professional liability coverage and follows federal and state laws protecting client's rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with other medical personnel involved in the treatment of my child. I have the right to be informed of these exchanges of information and may request more information about privacy laws, including HIPPA by writing to the Office of Civil Rights, Secretary of the U.S. Department of Health and Human Services.**
3. **I understand that Elise Tippett. LMSW may exchange information with the school staff and have access to my child's school file, as needed for treatment and care my child.**
4. **I understand that counseling is a fee for service agreement and that my insurance company will be billed for services. I further understand that I will be responsible for any portions of fees and/or additional fees not covered by my insurance provider. AHC encourages parents/guardians to contact their child's insurance company directly so you are informed about Behavioral Health services coverage for your child. It is a parent/guardian responsibility to know your insurance benefits. Alcona Health Center will not be contacting your insurance company directly to inquire about Behavioral Health services coverage in order to begin services with your child. You may be eligible for AHC's Sliding Fee program. Ask your therapist for details.**
5. **I understand that AHC has taken steps to minimize exposure to COVID-19 in all school locations based on CDC guidelines. I understand that if my child appears in poor health, I may be contacted to reschedule their appointment until symptoms are evaluated by a medical professional. If I have any concerns regarding COVID-19, I will contact my child's therapist prior to their scheduled appointment.**
6. **I understand that federal and state regulations protect the confidentiality of my child's records maintained by this program, except when the following conditions exist:**
   a. **There is suspected evidence of child abuse, neglect, or danger to my child; or**
   b. **The Michigan Department of Health and Human Services, Child Protective Services requests Behavioral Health information by directly submitting the DHS-1163-P form to Alcona Health Center and/or this Behavioral Health Therapist; or**
   c. **A medical emergency or public health concern, ie: COVID-19, requires disclosure to medical personnel; or**
   d. **"Duty to Warn(homicide threat/injury to another person) or Duty to Protect (suicide threat/injury to oneself)" or,**
   e. **The likelihood of alcohol or drug abuse, and**
   f. **My written permission is given to release this information, as you deem appropriate in good faith, to specific agencies or persons who are from time to time, authorized by law to receive such information.**

I HAVE READ AND UNDERSTAND THE CONDITIONS OUTLINED ABOVE, AND BY SIGNING BELOW AUTHORIZE Elise Tippett, LMSW TO OFFER BEHAVIORAL HEALTH SERVICES TO MY CHILD.

_____ _____

**Signature of Parent(s) or Legal Guardian** **Signature of Witness**

**Date: ____/_____/_____** **Date: ____/_____/_____**

**_____ My initials indicate that I have been offered a copy of AHC's Notice of Privacy Practices**. The notice is available at: www.alconahealthcenters.org or www.petoskeyschools.org/departments/behavioral-health-therapists/. Your therapist is also happy to give you a paper copy.

alcona citizens for health, inc.
dba
alcona health center "Your family health center"

**Authorization to Share Health Information**

_____

Printed Name of Person Whose Information is Being Requested Date of Birth

_____

Present address

I authorize and request the Alcona Health Center to obtain or release the following confidential health information contained in my medical records including information about:

- Behavioral and mental health services including referrals and treatment for alcohol and substance abuse disorder
- Communicable diseases and infections, such as tuberculosis ("TB"), sexually transmitted diseases, hepatitis B, Human Immunodeficiency Virus (HIV Infection, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or other information as described below:

_____

Please □ get information from: OR □ release the above information to:

Sheridan Elementary School Staff 231-348-2140

_____ _____

Name Telephone Number

1415 Howard St. Petoskey, MI 49770

_____ _____

Address City, State Zip Code

Format to be used: □ Hard Copy □ Verbal □ Telephone/Fax □ e-mail_____@_____

By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I am the client or am authorized to act on behalf of the client and can have a copy of this form

Time Period to be covered: _____ Consent expires on: _____

(If expiration date is left bland or is longer than one year, the consent will expire 1 year from the signature date.)

I have read this form or have had it read to me. I have had my questions about this form answered.

_____

Client (or responsible representative) Signature Date

_____

Print name if responsible representative Authority/Relationship to Client

_____

Witness Signature Date

alcona citizens for health, inc.
dba
alcona health center "Your family health center"

## Authorization to Share Health Information

_____

Printed Name of Person Whose Information is Being Requested Date of Birth

_____

Present address

I authorize and request the Alcona Health Center to obtain or release the following confidential health information contained in my medical records including information about:

- Behavioral and mental health services including referrals and treatment for alcohol and substance abuse disorder
- Communicable diseases and infections, such as tuberculosis ("TB"), sexually transmitted diseases, hepatitis B, Human Immunodeficiency Virus (HIV Infection, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or other information as described below:

_____

Please □ get information from: OR □ release the above information to:

Char-Em ISD 231-547-9947

_____ _____

Name Telephone Number

08568 Mercer Blvd Charlevoix, MI 49720

_____ _____

Address City, State Zip Code

Format to be used: □ Hard Copy □ Verbal

By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I am the client or am authorized to act on behalf of the client and can have a copy of this form

Time Period to be covered: _____ Consent Expires on: _____

(If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date.)

I have read this form or have had it read to me. I have had my questions about this form answered.

_____

Client (or responsible representative) Signature Date

_____

Print name if responsible representative Authority/Relationship to Client

_____

Witness Signature Date

alcona citizens for health, inc.
dba
alcona health center "Your family health center"

# Authorization to Share Health Information
# Physician Release

_____

Printed Name of Person Whose Information is Being Requested Date of Birth

_____

Present address

I authorize and request the Alcona Health Center to obtain or release the following confidential health information contained in my medical records including information about:

- Behavioral and mental health services including referrals and treatment for alcohol and substance abuse disorder
- Communicable diseases and infections, such as tuberculosis ("TB"), sexually transmitted diseases, hepatitis B, Human Immunodeficiency Virus (HIV Infection, Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or other information as described below:

**Please** □ get information from:
□ release the above information to:

_____ _____

**Physician/Office Name** **Telephone Number**

_____ _____

**Address** **City,** **State** **Zip Code**

Format to be used: □ Hard Copy □ Verbal

By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I am the client or am authorized to act on behalf of the client and can have a copy of this form

Time Period to be covered: _____ Consent Expires on: _____
(If expiration date is left bland or is longer than one year, the consent will expire 1 year from the signature date.)

I have read this form or have had it read to me. I have had my questions about this form answered.

_____

Client (or responsible representative) Signature Date

_____

Print name if responsible representative Authority/Relationship to Client

_____

Witness Signature Date

Please list ALL doctors, clinics, specialists, etc. who have treated your child in the past:

_____

_____

_____

_____

**If you need to elaborate on any of the topics, simply enter any additional information on the back of the forms.**

## PLEASE ANSWER THE FOLLOWING HEALTH-RELATED QUESTIONS

### LABOR & DELIVERY

1. Did the patient's mother have prenatal care? ___No __ Yes Where? _____
2. Were there any complications during pregnancy? __No ___Yes What? _____
3. Did the mother take any meds during pregnancy? __No __Yes List: _____
4. Did the mother take any controlled meds during pregnancy? __No __Yes List: _____
5. Did mother use any street drugs during pregnancy? __No __Yes List: _____
6. Did mother drink alcoholic beverages during pregnancy? __No __Yes How much? _____
7. Where was the child born? (Hospital, City, State) _____
8. Was the delivery vaginal? __No __Yes Was the delivery by C-section? __No __Yes
9. Were there any problems with the labor or delivery? __No __Yes List: _____
10. Were forceps or suction appliances used in delivery? __No __Yes
11. Was the baby full-term? ___No __Yes If not, delivered at how many weeks? _____
12. What was the baby's weight at birth? ____lbs ___oz. What was baby's length? _____ inches
13. Did the baby have any problems at birth? __No __Yes List: _____
14. How long was the baby's initial hospital stay? _____

### HEALTH MAINTENANCE

1. Has the patient had health care from another clinic? __No __Yes Where? _____
2. Please provide your child's immunization record.
3. Your child's diet includes: (check as many as are a part of the patient's diet)

___ Breast Milk ___ Veggies ___ Fruits ___ Meat ___ Formula ___ Milk ___Juices ___ Soda Pop

___Beans, eggs & dairy ___ Cereals ___ Breads ___Junk food ___'fast food' ___ Sweets

4. Does your child have regular bowel movements? __No __Yes ___Constipation ___Frequent loose stools
5. Does your child have normal urination____ Does your child have burning with urination? _____ since when? _____
6. If older than 3 years old, does you r child wet the bed? _____

### FAMILY AND SOCIAL HISTORY

1. The following people live in the *same household* as your child:

| NAME | AGE | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |
| | | |

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

2. Does anyone in the house smoke? _____ Does anyone smoke in the vehicle with the child present? _____

3. Check any of the following problems that have affected your child's immediate family (siblings, parents, grandparents, Blood-related aunts or uncles, first cousins)

| | | |
|---|---|---|
| ❑ Infant deaths, SIDS, stillborn infants | ❑ Birth Defects: List: | ❑ Cancer List location: |
| ❑ Autoimmune Disease | ❑ Drug Dependency | ❑ Alcohol Disorder |
| ❑ Heart Attack | ❑ Seizures (epilepsy) | ❑ Asthma |
| ❑ Mental Illness | ❑ Attention Deficit Disorder | ❑ Arthritis |
| ❑ Diabetes | ❑ High Blood Pressure | ❑ Other: |

List people who take care of your child: _____

_____

_____

| About the parents: **Mother** | **Father** |
|---|---|
| | |
| Level of education achieved: | Level of education achieved: |
| Occupation: | Occupation: |

## DEVELOPMENT

1. Did your child first sit alone before 7 months of age? ___Yes ___No When? _____
2. Did your child first walk alone before 15 months of age? __Yes __No When? _____
3. Does your child speak as well as others their age? ____ Do you have difficulty understanding their speech? ____
4. Do you think your child has difficulty seeing? ____ Do you think your child has difficulty hearing? ____

5. Describe your child's behavior by marking the appropriate boxes:

| Behavior | Major Problem | Minor Problem | No Problem |
|---|---|---|---|
| **Clinging** | | | |
| **Temper Tantrums** | | | |
| **Easily Frightened** | | | |
| **Short Attention Span** | | | |
| **Difficulty sitting still** | | | |
| **Aggressive** | | | |
| **Dislikes School/ Poor Grades** | | | |

6. Has your child ever been seen by a professional counselor for any reason? _____

_____

7. Do you have any concerns with your child's development? _____

_____

## MEDICAL HISTORY

1. Has your child ever been hospitalized? __No __Yes When, where and why? _____
2. Has your child ever had surgery? ___No __Yes Procedure: _____
3. List any medications your child is taking: _____
4. Has your child ever had a reaction to a med or immunization? ___No ___Yes List: _____
5. Check if the child has had any of the following health conditions:

| | | |
|---|---|---|
| ❑ Seizures | ❑ Asthma | ❑ Heart Murmur |
| ❑ Kidney or bladder infection | ❑ Ear Infection | ❑ Unusual bleeding |
| ❑ Eczema | ❑ Depression | ❑ If female, age menses started |
| ❑ Sleeping difficulties | ❑ Frequent abdominal pain | ❑ Frequent chest pain |
| ❑ Arthritis | ❑ Anemia | ❑ Diabetes |
| ❑ Frequent headaches (describe) | ❑ Broken Bones-list | ❑ Allergies: List |

FOR BEHAVIORAL HEALTH PROGRAMS ONLY:

What is the main reason(s) you are seeking support for your child? (Please include how long he/she has had these symptoms/concerns and any recent/past events contributing to these symptoms.)

_____

_____

_____

What are your hopes regarding your child's therapy?_____

_____

_____

Please list any current or past behavioral health therapy your child/family has participated in.

_____

_____

Has your child experienced any recent or past stressors? Yes No (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? If yes, please describe:_____

_____

_____

_____

How stressful would you rate your family life? 1 2 3 4 5 Highly Stressful
Please explain:

_____

_____

_____

**List any issues you may want to discuss with the healthcare provider at this first appointment:**

| |
|---|
| |
| |
| |
| |
| |
| |

| **Our Questions *for children 13 and older*** | ***THEIR* answers:** |
|---|---|
| Do you exercise regularly? If so, how often? | |
| What kind of exercise do you do? | |
| Do you eat a low-fat diet? | |
| Do you smoke? If so, how often, how many, how many years? | |
| Do you drink alcoholic beverages? If so, what, amount, how often? | |
| Are there any domestic abuse issues in your household? | |
| Are you tense, fearful, or anxious? | |
| Do you often feel worthless, blue, or sad? | |

**We offer a Sliding Fee program to qualified patients that reduce the cost of medical care at our facility. Ask our staff for an application! We will need to know your annual income when determining eligibility for this program. You can be sure we will hold this information in the strictest of confidence!**

**We ask that you to provide us with your approximate family income**. This information is used solely for organization-wide demographic data, for sliding fee consideration, and not for any other purposes. It is not shared with anyone except in aggregate and no one is mentioned by name in reports. Approximate Family Income $ _____

## PCMH- PATIENT CENTERED MEDICAL HOME

**ALCONA HEALTH CENTERS IS A PATIENT-CENTERED MEDICAL HOME.** We are focused on your child's wellness. We have created a wide range of services and resources designed to:

- Track and monitor the care received from all of health care providers
- Help your child meet health-related goals and grow into healthy adults
- Offer your child extended access to our health care team

Welcome to Alcona Health Centers. We are honored to be considered for your child's healthcare management. We're committed to providing your child with the best care.

It is our expectation that you'll take responsibility for guiding your child in adapting a healthy lifestyle as that is so important to your child's well-being.

We will be discussing with you some important steps you can encourage with your child to maintain or achieve good health. Your cooperation is vitally important.

It will give our staff and providers great pleasure to work with you on these goals, either through our own expertise, through reading materials that we might give you, or by referral to other health professionals. We want everyone to be involved in our health maintenance program. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups that may include health assessments and education.

We are looking forward to working with you as your family healthcare providers. Please contact us whenever you'd like to talk about anything you think may be affecting your child's health. It's our hope that we can have a relationship where the lines of communication are open and communication goes both ways. We will help you remember when your child is due for wellness exams and/or immunizations.

Self-management goals are a series of small steps you can take to help your child work towards achievable health care goals. We will support you and assist you in identifying achievable action steps, when needed.

*Revised: 10/22/2015 MW, 02/28/2018 AAG*