

**A CHANCE TO GROW / New Visions School**  
**HEALTH HISTORY FORM**

Date \_\_\_\_\_

Dept. \_\_\_\_\_

Staff Init. \_\_\_\_\_

**Client:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (home): \_\_\_\_\_ (work): \_\_\_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_ Special Education received? Yes No

Does client prefer his/her right or left hand? Right \_\_\_\_\_ Left \_\_\_\_\_

How did you hear about our agency? \_\_\_\_\_

**Parent(s) or Guardian(s) of minor:**

Name(s): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Is child adopted? \_\_\_\_\_

Does client prefer his/her right or left hand? Right \_\_\_\_\_ Left \_\_\_\_\_

Mother: right or left handed? Right \_\_\_\_\_ Left \_\_\_\_\_ Father: right or left handed? Right \_\_\_\_\_ Left \_\_\_\_\_

Are biological siblings right or left handed? \_\_\_\_\_

What are your main concerns about your child right now? \_\_\_\_\_

**Physician or Other Health Care Professional:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Any other Physician or Professional seen: \_\_\_\_\_

Any chronic medical conditions: \_\_\_\_\_

Briefly list other approaches you have tried for this condition (medication, behavior therapy, counseling, alternative medicine, etc.) \_\_\_\_\_

Medications currently taken: \_\_\_\_\_

List any special diets or indicate g-tube feedings: \_\_\_\_\_

**Insurance Information**

Insurance company name: \_\_\_\_\_

Policy number: \_\_\_\_\_

Name of insured: First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to client/student: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_

\*Please indicate if the client and/or family members (parents, grandparents, brothers, sisters, aunts, uncles, and /or children) currently experience or have a history of any of the following:

**Behavior Characteristics:**

**Behavior Characteristics:**

	Client currently	Client in past	Family current or history		Client currently	Client in past	Family current or history
Feeling tense	___	___	___	Physical aggression	___	___	___
Depressed	___	___	___	Stubbornness	___	___	___
Always on the go	___	___	___	Addictions	___	___	___
School/work problems	___	___	___	Impulsivity	___	___	___
Hyperactivity	___	___	___	Attention problems	___	___	___
Behavior problems	___	___	___	Vocal or motor tics	___	___	___
Sleep problems	___	___	___	Legal trouble	___	___	___
Feeling lonely	___	___	___	Repetitive thoughts	___	___	___
Repetitive behavior	___	___	___	Shy with people	___	___	___
Memory problems	___	___	___	Temper tantrums	___	___	___
Rages	___	___	___	Verbal aggression	___	___	___
Chronic fatigue	___	___	___	Poor self esteem	___	___	___
Picky eater	___	___	___	Nightmares	___	___	___
Alcohol/drug problem	___	___	___	Feeling panicky	___	___	___
Tremors	___	___	___	Suicidal ideas	___	___	___
Physical/sexual abuse	___	___	___	Over ambitious	___	___	___
Unable to relax	___	___	___	Can't make decisions	___	___	___
Communication prob.	___	___	___	Problems at home	___	___	___
Financial problems	___	___	___	Dislikes school	___	___	___
Withdrawn	___	___	___				

**Psychological Stress/Life Changes:**

Within the past <b>24 months</b> , the client has experienced:	x if yes	x if no
Death in the family	___	___
Divorce / remarriage	___	___
Move / relocation	___	___
School change	___	___
Job change	___	___
Family member chronic illness	___	___

Provide any additional information you would like here: \_\_\_\_\_

**Medical:**

	Client currently	Client in past	Family current or history		Client currently	Client in past	Family current or history
Headaches	___	___	___	Frequent illness	___	___	___
Allergies*	___	___	___	Asthma	___	___	___
Seizures**	___	___	___	Chronic pain	___	___	___
Food sensitivity	___	___	___	PMS	___	___	___
Bowel disturbances	___	___	___	Dizziness	___	___	___
Fainting spells	___	___	___	Heart palpitations	___	___	___
Stomach trouble	___	___	___	Poor appetite	___	___	___
Diabetes	___	___	___	Heart problems	___	___	___
High blood pressure	___	___	___	Thyroid (hyper/hypo)	___	___	___

Estimated # courses of antibiotics \_\_\_\_\_

\*List Allergies: \_\_\_\_\_

\*\*Frequency and type of seizures: \_\_\_\_\_

List any illnesses in the last 24 months: \_\_\_\_\_

**Prenatal Medical History:**

The client experienced:	x if yes	x if no		x if yes	x if no
Prenatal stress or injury	___	___	Low birth weight	___	___

The client experienced:	x if yes	x if no		x if yes	x if no
Prenatal stress or injury	___	___	Low birth weight	___	___
Prenatal drug/alcohol exposure	___	___	Premature delivery	___	___
Birth trauma (forceps, breech, etc.)	___	___	Late delivery	___	___
Anesthesia, pain medications	___	___	Medical problems	___	___
<b>Physical Traumas:</b>					
The client experienced:	x if yes	x if no		x if yes	x if no
Head injury	___	___	Coma	___	___
Accidents	___	___	High fever	___	___
Serious illness	___	___	Surgery	___	___
CNS infection	___	___	Drug overdose	___	___
Recreational drug use	___	___	Poisoning	___	___
Stroke	___	___	Anoxia	___	___
Provide any additional information you would like here: _____					

**Vision:**

	Client currently	Client in past	Family current or history
Able to read comfortably as long as needed	___	___	___
Letter or word reversals are a concern	___	___	___
Reading comprehension below expected levels	___	___	___
Skips lines when reading	___	___	___
Difficulties with seeing in the distance	___	___	___
Difficulties with seeing while reading	___	___	___
Experiences eye strain/eye rubbing while reading	___	___	___
Experiences double vision	___	___	___
Wears glasses	___	___	___
Cataracts	___	___	___
Glaucoma	___	___	___
"Lazy" eye	___	___	___
Retinal detachment	___	___	___
If client wears glasses, they are worn:			
	All of the time___	Distance only___	Near only___ Rarely___
List any diagnosis related to vision (i.e. field cuts, legally blind): _____			
Provide any additional information you would like here: _____			

**Auditory/Speech/Language:**

The client:	x if yes	x if no
Has a hearing loss	___	___
Frequently asks to have directions repeated	___	___
Has a history of multiple ear infections	___	___
Has structural or functional mouth abnormalities	___	___
Says his/her words clearly	___	___
Is easy to understand when speaking	___	___
Combines words into meaningful sentences	___	___
Is exposed to two or more languages in his/her home	___	___
Frequently misunderstands what is said	___	___
Says "Huh" or "What" often	___	___
Is easily distracted by background noise	___	___
Has difficulties with speech/sound discrimination	___	___
Doesn't remember auditory information	___	___
Struggles with academics, especially reading and spelling	___	___
Approximate age client began using meaningful words: _____		
Current length of client conversational speech sentences: _____		
Provide any additional information you would like here: _____		

**Developmental:**

Provide any additional information you would like here: \_\_\_\_\_

**Developmental:**

The client:	x if yes	x if no
Belly crawled	___	___
Creeped on hands and knees	___	___
Is well coordinated (playing games, i.e.catch)	___	___
Has good writing skills for his/her age	___	___
Has an unusually high or low pain tolerance	___	___
Has certain textures he/she avoids touching	___	___

Provide any additional information you would like here: \_\_\_\_\_

**General Questions**

What radio station(s) do regularly listen to: \_\_\_\_\_ 1st \_\_\_\_\_ 2nd

What television channel do you usually watch for news:

\_\_\_ WCCO(4) \_\_\_ KSTP(5) \_\_\_ KMSP(9) \_\_\_ KARE(11) \_\_\_ Other \_\_\_ None

What newspapers do you regularly read:

___ Minneapolis Star Tribune	___ Family Times
___ St. Paul Pioneer Press	___ Parent Times
___ North News	___ Sun Post _____
___ NorthWest News	___ SouthSide Pride
___ NorthEast News	___ Minneapolis Spokesman
___ Camden Community News	___ Other
___ None	

do you have a special talent or hobby you could teach our children about, or would you like to volunteer to assist on field trips, classroom special events, or with daily program needs? \_\_\_yes \_\_\_no

Please explain: \_\_\_\_\_

Does your employer offer any programs (ie. monitoring, matching funds, etc.) that might help us in our work with your and other children? \_\_\_yes \_\_\_no

Please explain: \_\_\_\_\_

Would you like to receive our Growing Times Newsletter? \_\_\_Already receive \_\_\_yes \_\_\_no



**New Visions School**  
**1800 Second Street Northeast**  
**Minneapolis, MN 55418**

**CONSENT  
 TO RELEASE  
 PRIVATE DATA**

Student's full Name \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade \_\_\_\_\_

School: New Visions School

Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_

I authorize \_\_\_\_\_ District# \_\_\_\_\_  
School District Name and Person Responsible

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
(check either or both boxes, as needed)

to release information **to:**  to obtain information **from:**

Name, Title \_\_\_\_\_

Organization New Visions School District 4011

Address 1800 second Street Northeast

City Minneapolis, MN St \_\_\_\_\_ Zip \_\_\_\_\_

Student records may be examined by parent(s), or by student if age 18 or older.

The information to be released:

- Official School Records (Name, address, birth date, sex attendance record, grade level, class rank, standardized group test results)
- Health Record  Chemical Abuse/Dependency Reports
- Psychological reports  Medical Report (including related services)
- Special Education Records (including related services)
- Teacher, Counselor, Staff Observations  Psychiatric Report
- Social work Report
- Others (specify) \_\_\_\_\_
- Others (specify) \_\_\_\_\_

The purpose for the request \_\_\_\_\_

I understand that this authorization takes effect the day that I sign it. It expires on \_\_\_\_\_  
 or no more than one year from the date of my signature. (M/D/Y)

I also understand that I may change this authorization at any time.

\_\_\_\_\_  
 Parent signature, or Student if age 18 or older (M/D/Y)

This form is available in several languages, Braille, or other format.  
 Contact the director of special education.

Date \_\_\_\_\_  
(M/D/Y)  
 Copies: Due Process File Parent  
 IEP Manager IFSP Service Coordinator