



Health Tracks Health History Form

Rolette County Public Health District
211 1st Ave NE PO Box 726 Rolla ND 58367 701-477-5646

Adapted from ND Department of Human Services/Department of Health SFN 1818 (Rev. 2-2011)

Public Health
Prevent. Promote. Protect.

Name:		Date of Birth:	Race:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:		City:	State:	Zip Code:
Medicaid Number:	Social Security Number:	Telephone Number 1:	Telephone Number 2:	
Information Provide by:	Name of Parent/Guardian:	Child Lives at Home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Would be willing to accept text messages at following number:	
Child in Foster Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Case Manager (if applicable):	Other Agencies Involved (WIC, infant tracking,ect):		

Family Members/People Living in Household

First	Last	Name (Maiden)	Sex	Marital Status	Relationship to Child	Date of Birth	Age

Past Health History

Has Child Ever Had:	No	Yes	Comments	Has Child Ever Had:	No	Yes	Comments
Communicable Diseases (Hep C., Chicken pox, Measles, RSV, etc.)				Depression/Anxiety			
Convulsions/Seizures(other than febrile)				Skin Disorders (Dermatitis, Eczema, Rashes, Acne)			
Breathing Disorders/Asthma/ Inhaler or Nebulizer Use				Vision Disorders (Glasses, Surgery, Eye Patch, etc.)			
Seasonal Allergies (Hayfever)				Dental Surgery			
Multiple Ear Infections/Tube Placement				Surgery/Accidents/Serious Injuries/Fractures			
Learning Disabilities/ADHD				Other:			

Current Medications

- Child Takes No Medications
 Child is Currently Taking Medications. List Medications _____

Medications administered at home at school other: _____

No known allergies Allergies (please list) _____

Immunizations up to date. If not, list reason: _____

Health Care Providers

Provider	Location	Date Last Seen
Doctor:		
Eye Doctor:		
Dentist:		
Orthodontist		
Specialist:		
Counselor:		

Developmental Review

Does the child have trouble in any of the following areas NOW:		
Sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Isolation
Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequently ill
Temper Tantrums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bullying
Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nightmares
		Excessive Fears
		Decision Making
		Weight Loss
		Weight Gain
Is the child difficult to parent? <input type="checkbox"/> No <input type="checkbox"/> Yes -- Explain:		
Are there any other problems not mentioned above?		
Are there any concerns about:		
<input type="checkbox"/> Drinking Alcohol <input type="checkbox"/> Drug Use <input type="checkbox"/> School Performance <input type="checkbox"/> Choice of Friends <input type="checkbox"/> Mood/Attitude <input type="checkbox"/> Peer Pressure <input type="checkbox"/> Eating/Sleeping <input type="checkbox"/> Harming Self (self-mutilation) <input type="checkbox"/> Sexual Activity		
Have there been any changes in family dynamics?		
<input type="checkbox"/> Separation/Divorce <input type="checkbox"/> Recent move <input type="checkbox"/> Loss of job <input type="checkbox"/> Death of relative or close friend <input type="checkbox"/> Gain of new family member		
Dose the family have someone to call for help in case of family problems?		If unable to be reached by phone, is there a number to leave a message for you to receive: _____-_____-_____

School Information

What grade is child currently in?	
<input type="checkbox"/> Head Start <input type="checkbox"/> Preschool <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th <input type="checkbox"/> 7 th <input type="checkbox"/> 8 th <input type="checkbox"/> 9 th <input type="checkbox"/> 10 th <input type="checkbox"/> 11 th <input type="checkbox"/> 12 th <input type="checkbox"/> GED courses <input type="checkbox"/> College <input type="checkbox"/> Alternative School Name of school _____	
Is the child in any special classes (speech, reading)?	Does the child take part in other activities (sports, music)?
<input type="checkbox"/> No <input type="checkbox"/> Yes, list: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, list: _____
Have there been any changes in school performance?	Other comments/concerns related to school?
<input type="checkbox"/> No <input type="checkbox"/> Yes, list: _____	

Summary/Additional Comments:	
Signature of Intake Worker/Form assisted by:	Date:

Consents

As parent/legal guardian/self, I hereby give my consent to release screening assessment information and to have him/her/myself undergo laboratory tests, examinations, and immunizations under the MCH/Health Tracks program for completion of the screening, diagnosis, and treatment and waive any legal action against any/all persons conducting the program. Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect participation in this program. Consent remains in effect for one year from date of signature.	
Fluoride varnish helps to protect teeth from cavities. Fluoride varnish may be applied to my child's teeth 2-4 times per year. My child's teeth may look yellow for 24 hours after application. After receiving fluoride varnish, my child should not drink pop or have chips, candy, gum or other crunchy foods for one day. My child should wait until the next morning to brush their teeth and then can then resume normal oral hygiene. I understand that the oral screening my child receives is not a complete dental exam.	
<input type="checkbox"/> Yes, I give permission for my child to participate in the fluoride varnish program	<input type="checkbox"/> No, I do not give permission for my child to participate in the fluoride varnish program.
Federal HIPAA Privacy Regulations are maintained by Rolette County Public Health District and Health Tracks Program Staff. Their Notice of Privacy Practices is available on site. I understand I may request a copy of RCPHD's Notice of Privacy Practices at any time.	
Signature (parent/legal guardian/self):	Date:
X	