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***\* You can edit the tool to make it look how you want. You can take sections or rows away or add some more! Write whatever you want but try to keep it short. \****

|  |  |
| --- | --- |
| **Name (first, last):** |  |
| **The name I (or my child) like to use:** |  |
| **Gender:** |  |
| **Pronouns (e.g., he/she/they/xe):**   |  |  | | --- | --- | | **Do my parents know about my pronouns?** | **☐ Yes**  **☐ No**  **☐ N/A** | | |
| **Birthday (YYYY/MM/DD):** |  |
| **Preferred language(s):** |  |
| **Allergies (e.g., food, medication)** | **☐ No**  **☐ Yes, I am allergic to:** |
| **Food or environmental**  **sensitivities (e.g., gluten, sugar, scents)** | **☐ No**  **☐ Yes, I am sensitive to:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Health condition(s) / diagnosis  **Name of condition/diagnosis and year of diagnosis**   |  | | --- | |  | |  | |  |   **Treatment (e.g., medication, therapy):**   |  | | --- | |  | |  | |  |   **Current symptoms (how it makes me/my child feel):**   |  | | --- | |  | |  | |  |   **How I (or my child) keep track of symptoms:**   |  | | --- | |  |   **How I (or my child) manage (e.g., what has worked, what has not worked?)**   |  | | --- | |  |   **Are symptoms getting better or worse? ☐ Better ☐ Worse**  **In the last three months have there been any new symptoms unrelated to my (or my child’s) current health condition/diagnosis:**   |  | | --- | |  |   Hospital history   |  |  |  | | --- | --- | --- | | **Date of most recent hospital visit (YYYY/MM/DD)** | **Reason for the visit** | **Treatment / Follow-up plan** | |  |  |  | |  |  |  | |  |  |  | |

Medication history over the past year

|  |  |
| --- | --- |
| **Medication name(s):** | 1.  2.  3. |
| **Reason for medication:** | 1.  2.  3. |
| **Dose (how much) and frequency (how often):** | 1.  2.  3. |
| **Status (still using/ paused/stopped):**  **If stopped, include why.** | 1.  2.  3. |
| **Adverse or allergic reactions (e.g. negative side effects)** | 1.  2.  3. |

**☐ My (or my child’s) medications, their purpose, and side effects have been explained to me.**

Getting services

|  |  |
| --- | --- |
| **Are there any challenges that make it more difficult for you (or your child) to get appointments with medical professionals?** | **What would help make it easier for you (or your child) to get services or make appointments?** |
| **Examples:** transportation, cost, conflict with work/school, anxiety) | **Examples:** appointments on certain days/times, things to put in the waiting room, things you/your child needs while waiting for services or during services. |
|  |  |
|  |  |

Your (or your child’s) strengths, challenges, and triggers:

|  |  |
| --- | --- |
| **Strengths**  (e.g., loves sports, loves animals) |  |
| **Challenges**  (e.g., gets nervous around new people) |  |
| **Triggers**  (e.g., needles, blood) |  |

Who are the people involved in your (or your child’s) care:

|  |  |  |
| --- | --- | --- |
| **Name** | **Role** | **Contact information (phone number/email address)** |
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