HEALTH STATUS

Name: ______________________ Date of Birth: ______________________

1. Have you had a history of, or treatment for, any of the following:

	Yes	No		Yes	No
Tuberculosis			Heart Condition(s)		
Cancer			Mental Health		
Severe Arthritis			Hemophilia		
Chronic Kidney Condition			Substance Abuse		
Colitis			Chronic Headaches		
Sleep Disorder			Chronic Fatigue		
Seizures			Other? Please describe:		
Severe Allergies					

2. Have you ever received treatment for mental health? ☐ Yes ☐ No
   a. If yes, when? ______________________ From whom? ______________________

3. Have you ever gone to counseling? ☐ Yes ☐ No
   (ex; death in the family, marital issues, past trauma, or any other mental health issues, etc.)
   a. If yes, for what and when? ______________________

4. List all medications being taken on a regular basis:

Medication	Reasons for Medication

5. Do you have any physical disability? ☐Yes ☐ No
   a. If yes, can you please name the disability:______________________
   b. If yes, do you receive income from it? ☐ Yes ☐ No
      I. If yes, how often and how much? ______________________

6. Do you consume illicit drugs? ☐ Yes ☐ No
   a. If yes, how often and how much?______________________

7. Do you drink alcohol socially? ☐ Yes ☐ No
   a. If yes, how often and how much?______________________

8. Do you use nicotine products? ☐ Yes ☐ No
   a. If yes, where?______________________

9. **A statement may be needed from a physician, psychologist, or counselor concerning you and/or your child's past or current physical or mental health condition. Are you willing to give permission for release of such information if necessary?** ☐ **Yes** ☐ **No**

Signature of Foster/Adoptive Parent :______________________ Date: ______________

Signature of Household Member or Guardian: ______________________ Date: ______________