University Academy Wellness Center Questionnaire

Parents or legal guardian,

PLEASE COMPLETE THE FOLLOWING QUESTIONS ACCURATELY, FEEL FREE TO CALL THE CLINIC WITH ANY QUESTIONS (816-412-5978).

Health Concerns

What are your chief concerns about your child's health? ____________________

Learning Needs Assessment

1. Are there any cultural or religious practices that may affect your child's care or education? No___ Yes___
   If yes explain: ____________________
2. Are there any emotional/family/home concerns that you would like to talk to someone about? No___ Yes ___
   If yes explain: ____________________
3. Are there any conditions or circumstances that might be barriers to your child's ability to learn? No____ Yes____
   If yes explain: Vision ___ Reading ___ Hearing ___ Language ___ Learning Disability ___
   Other ____________________
4. Please check each item below that you think you need to learn more about:
   Meal planning/nutrition ___ Personal hygiene and care ___ Pain management ___ Medications ____
   Places to get help with money matters related to health care ____ other ____________________

Past Health History

Has your child ever been hospitalized overnight, had surgery, or had a serious injury? No ____ Yes ____
Age when hospitalized or injured ____________________
Description of Injury or reason for hospitalization or surgery ____________________

Has your child ever had any of the following health problems? If yes, give the child's age at which the problem started.

	No	Yes	Age of Onset		No	yes	Age of Onset
Allergies	____	____	____	Scoliosis	____	____	____
Asthma	____	____	____	Seizures	____	____	____
Diabetes/endocrine problems	____	____	____	Sickle cell anemia (low blood iron)	____	____	____
Headaches/migraines	____	____	____	Stomach or digestive problems	____	____	____
Heart problems	____	____	____	Urine or kidney problems	____	____	____
Mental illness or depression	____	____	____	Trouble hearing or seeing	____	____	____
Other ____________________							

School History

	No	Yes	
Does your child miss a lot of school?	____	____	
Is your child in a special class?	____	____	what kind (gifted, learning disability, etc)? ____________
Are you happy with your child's school performance?	____	____	
Does your child have plans after high school?	____	____	

What about your child makes you proud of him or her? ____________________

Family History

Have your child's blood relatives (parents, brothers, sisters, grandparents, aunts and uncles), living or deceased, had any of the following? Please list if relative is maternal or paternal.

	No	Yes	Relationship to child
Asthma	____	____	____________________
Blood disorders/sickle cell anemia	____	____	____________________
Cancer (type____________________)	____	____	____________________
Diabetes/endocrine disease	____	____	____________________
Heart attack or stroke	____	____	____________________
High blood pressure	____	____	____________________
Mental illness or depression	____	____	____________________
Obesity	____	____	____________________
Smoking	____	____	____________________

Form Completed by: ____________________ **Relationship to child:** ____________________