

Name: _____ Date of Birth: _____

Diagnosis: _____

Allergies: _____

Medications: _____

Today's Date: _____ Form Completed By: _____

Please answer the following questions about your health and development so we can help with your needs.
(YOU always refers to the YOUNG PERSON)

Staff Only	Health Questions	YES	SOME -TIMES	NO
F/U	Medical Home: _____			
	1. Do you have a medical home (family doctor or clinic) that you go to when you are sick or need a check-up?			
	2. Do you have regular check-ups with your medical home provider?			
	3. Are your immunizations up-to-date?			
	4. Do you feel that your general health is good?			
	5. Do you know when, how much, and why you take medications? (prescription and over-the-counter, like Tylenol)			
	6. Are you able to get the medications, therapy, supplies, and/or equipment you need?			
	7. Are you independent in your personal care?			
	8. Do you have friends that you spend time with at least once a week?			
	9. Have you thought about what you would like to do when you become an adult?			

