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**PHYSICAL FORM FOR CHILD OR ADULT**

To: \_\_\_\_\_

This form is provided for your convenience in responding to requested medical, dental or mental health information about this client. For more complex issues, a written narrative would be helpful. Copies of patients' records are not required. Documents specifically requested are indicated on the accompanying authorization letter signed by the patient/client or parent.

**Patient's name** \_\_\_\_\_ **DOB** \_\_\_\_\_

1. For what condition is the patient currently or most recently being treated?

\_\_\_\_\_

Dates of treatment: \_\_\_\_\_

2. Does this patient have any chronic or debilitating conditions? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

3. What treatment is recommended? \_\_\_\_\_

\_\_\_\_\_

4. Does this patient cooperate with treatment or therapeutic advice? \_\_\_\_\_

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

5. Has patient sought treatment when appropriate? \_\_\_\_\_ If no,  
please explain \_\_\_\_\_

\_\_\_\_\_

6. To your knowledge, does patient have any condition needing treatment  
that they are not attending to? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

7. Do you feel this patient is a danger to self or others? \_\_\_\_\_ If yes,  
Please explain \_\_\_\_\_

\_\_\_\_\_

8. Briefly give your opinion of the patient/parents strengths or weaknesses as  
a parent within the perspective of your contact with them and professional  
knowledge: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Are you this patient's primary care physician? \_\_\_\_\_

10. How many times have you seen this patient? \_\_\_\_\_

**If the patient/client is a child, please answer the following questions:**

11. Which parent or adult generally brought the patient for treatment?  
\_\_\_\_\_ mother \_\_\_\_\_ father \_\_\_\_\_ grandparent/guardian

12. Have you ever suspected neglect, physical, sexual or emotional abuse?  
\_\_\_\_\_ If yes, please explain: \_\_\_\_\_

13. Are you aware of any serious concerns expressed about this child from anyone? \_\_\_\_\_

14. Has the patient/child had all necessary checkups to date? \_\_\_\_\_  
If no, please explain; \_\_\_\_\_

15. Is the patient/child up to date on all necessary immunizations? \_\_\_\_\_  
If no, please explain: \_\_\_\_\_

16. Are you this child's primary care physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

17. How many times have you seen this child? \_\_\_\_\_

18. How many well child visits have been performed on this child? \_\_\_\_\_

19. Any current or continuing health problems? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please explain \_\_\_\_\_

20. Please make a brief statement as to the child's general health, growth and development;  
\_\_\_\_\_  
\_\_\_\_\_

21. Please list current medications that your patient is taking and the reason for taking them:

Name of Med	Dosage	Frequency	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Please print physician's name

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Physician's phone number