# HEALTH STATUS

(TO BE COMPLETED SEPARATELY FOR EACH PERSON IN THE HOME)

NAME_____ DATE OF BIRTH ____/____/_____

Do you have any serious medical conditions that could affect parenting? ___ Yes ___ No
If yes, when and what? _____

Have you ever been treated for drug usage? ___ Yes ___ No
If yes, when and where? _____

Have you ever been treated for alcoholism? ___ Yes ___ No
If yes, when and where? _____

Have you ever received treatment for mental problems? ___ Yes ___ No
If yes, when? From _____ to _____. From whom? _____

Have you taken medication for mental or emotional problems? ___ Yes ___ No

| Medication | Reason for Medication | Date Prescribed |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever gone to counseling for emotional or family problems? ___ Yes ___ No
If yes, when? From _____ to _____. Who was the counselor? _____

Have you ever had a psychological evaluation or battery of psychological tests? ___ Yes ___ No
If so, when? _____
List all prescription medications being taken on a regular basis.

| Medication | Reason for Medication | Date Prescribed |
|---|---|---|
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A statement may be needed from a physician, psychologist or counselor concerning your current physical, mental and/or emotional condition if you have any conditions that could affect your parenting ability. Are you willing to give permission for release of such information if necessary?
___ Yes ___ No

_____ _____
Signature of Person filling out Form Date

_____ _____
Interviewer Signature Date

This Health Status was reviewed by Home Study Interviewer with the family.