COLORADO
Department of Public Health & Environment

HCP for Children and Youth with Special Health Care Needs

HCP Specialty Clinic Medical History

Date _____ Clinic Location _____

Child/Youth's First Name _____ Child/Youth's Last Name _____

DOB _____ ☐ Male ☐ Female Primary Care Provider Name/Number _____

Medical Condition(s)	

Name(s) of Other Specialists	Prior Evaluations	Prior Tests/ Procedures

Allergies:

Brief Description of Concern: Describe Family/Child/Youth/Primary Care Provider Concerns and Questions below.

Relevant History: Describe relevant prenatal/ birth histories & current overall health status below.

Check all that apply & describe in the space below: ☐ None ☐ Accidents ☐ Surgeries ☐ Hospitalizations

Medication	Frequency/Doses	Notes

Therapies: ☐ None

☐ Physical Provided By: _____

☐ Occupational Provided By: _____

☐ Speech Language Provided By: _____

☐ Other Describe _____ Provided By: _____

Nutritional Concerns: Describe, if applicable. ☐ None

Growth & Development: Describe any concerns. ☐ Normal ☐ Delayed

Completed By: _____ Phone: _____

Relationship to child/youth: _____ Date _____

HCP Specialty Clinic Use Only ☐ Additional Family ☐ Social ☐ Behavioral Concerns ☐ Interest in Care Coordination

Clinic Coordinator: _____ Date _____