

**OSAGE NATION
CHILD AND FAMILY ASSESSMENT**

**SUPPLEMENTAL QUESTIONNAIRE
PARENT/GUARDIAN HEALTH**

1. How would you rate your overall health? (Check one)
 Excellent Above Average Average Poor Very Poor

2. Please explain why you rated your health as you did?

3. Do you have any allergies, disabilities, or chronic illnesses? Yes No
If yes, please list:

4. Are you currently taking any prescribed medications? Yes No
If yes, please list the medications and what they are for:

5. Where do you go to receive medical attention?

6. Are you covered by insurance? Yes No
If yes, please list type of insurance:

7. Check any of the following that apply:
 I have regular medical checkups
 I have regular dental checkups
 I currently see a therapist/counselor

8. Have you ever been hospitalized or had surgery performed? Yes No
If yes, please explain:

9. Have you ever experienced any depression? Yes No
If yes, please explain:

10. Have you ever talked with a counselor or therapist? Yes No
If yes, when did you see the counselor or therapist?

What did you see the counselor or therapist for?

11. Have you ever had a mental health evaluation? Yes No
If yes, please explain:

12. Have you ever thought about harming yourself? Yes No
If yes, please explain:

13. Have you ever tried to commit suicide? Yes No
If yes, please explain:

14. Do you have any physical limitations that we should be aware of? Yes No
If yes, please explain:

15. Does your family have a history of diabetes? Yes No
If yes, please explain:

16. Has anyone in your family ever had problems with alcohol? Yes No
If yes, please explain:

17. Please write any comments or questions that you have regarding your health and/or information about resources/services: