STATE OF ALASKA
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC ASSISTANCE

DPA Use Only
DPA Office: _____ Date: _____
Case #: _____

CHILD'S MEDICAL HISTORY AND DISABILITY REPORT

Be sure the form is complete. If you need more space for any answer, use another piece of paper. Please print clearly.

Name:_____

Social Security Number: _____

Address:_____

_____

Phone:_____

To assist in the disability determination, please attach any documentation about the child's condition that you have.

I. INFORMATION ABOUT YOUR CONDITION

A. What is your child's disabling condition? Briefly describe the disabling illness or Injury._____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

B. When did your child become disabled? (MM/DD/YY)

C. Has your child worked since he/she became disabled? YES ☐ NO ☐

D. Explain how your child's condition affects him/her and keeps him/her from performing daily activities._____

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II. INFORMATION ABOUT YOUR TREATMENT

Give the name, address, and telephone number of medical providers, hospitals, or clinics Where your child has received treatment for the condition(s) that disabled him/her. *For more than five providers, make a copy of this blank page and attach.*

A._____ _____
Name of physician/facility Dates first/last treated

_____ _____
Address Phone number

B._____ _____
Name of physician/facility Dates first/last treated

_____ _____
Address Phone number

C._____ _____
Name of physician/facility Dates first/last treated

_____ _____
Address Phone number

D._____ _____
Name of physician/facility Dates first/last treated

_____ _____
Address Phone number

E._____ _____
Name of physician/facility Dates first/last treated

_____ _____
Address Phone number

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III. Has your child been seen by other agencies for his/her disabling condition? (VA, Vocational Rehabilitation, Social Security, etc.) YES ☐ NO ☐

If YES, please complete the following.

NAME OF AGENCY	ADDRESS	PHONE
_____	_____	_____
NAME OF AGENCY	ADDRESS	PHONE
_____	_____	_____
NAME OF AGENCY	ADDRESS	PHONE
_____	_____	_____

IV. MEDICAL/MENTAL TESTS

Has your child had any of the following tests in the last 2 years?

Electrocardiogram_____ Chest X-ray_____ X-rays (other)_____ Blood tests_____

Pulmonary test_____ MRI/CT_____ Mental test_____ Psychological test_____

V. MEDICATION YOUR CHILD IS TAKING OR HAS TAKEN IN THE LAST 2 YEARS.

_____

_____

_____

VI. EDUCATION LEVEL

What is the highest grade your child has attended?_____

_____ _____
Name and address of school Dates attended

_____ _____
Name and address of school Dates attended

Does the child read, write, or speak English? YES ☐ NO ☐

If NO, what language?_____

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VII. ACTIVITIES (If more space is needed, use a separate piece of paper.)

A. Is the child able to care for personal needs (bathing, dressing, toileting, toothbrushing, hair brushing, etc.)? Are there any special problems in this regard?

B. Describe the child's daily activities. Start from the time the child wakes up and describe a typical day until he/she goes to bed. List the limitations in activities that your child has compared to his or her playmates of the same age. Give specific examples.

C. What does the child do when he/she is not in school? How long and how often does he/she do these things?

D. Is the child expected to help with household chores? If yes, what are the chores? How often are they done? How well are they done? How much supervision is required?

E. Describe the child's friends and playmates; their ages, activities, how often, and how they play together. Please list the limitations in activity your child experiences as compared to his or her playmates of the same age. Give specific examples.

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F. How well does the child behave with adults (parents, other family members, teachers, and neighbors)? Please give examples.

G. How many other children live with this child? What are their ages? Describe how the child interacts with them.

H. Describe in full any "problem" behaviors. For example, serious fighting, stealing, bedwetting, withdrawal from others, etc. Also, describe how frequently any of these behaviors occur.

I. Does the child miss school regularly? How often and why?

J. How frequently does your child see a doctor due to illness and how frequently has your child been hospitalized or seen in the Emergency Room in the past year?

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VII. ADDITIONAL INFORMATION OR COMMENTS

_____

_____

_____

_____

_____

I understand that my report will be used in conjunction with information provided by my physician and hospital to determine my child's disability claim. This information I have provided is strictly voluntary. Failure to provide all or part of the information requested may affect the determination of my child's claim.

Signature of Applicant: _____
Signature **Date (month/day/year)**

Witness if signed with an "X": _____
Signature **Date (month/day/year)**

Signature of Authorized Representative: _____
Signature **Date (month/day/year)**

****

(This section for agency use only)

1. Interview was conducted face to face with client_____ client's representative_____.

2. Interview was conducted over the phone_____, thru an interpreter_____, thru an agent_____.

3. Client was_____was not_____present at the interview.

4. Client had difficulty with the following:

reading_____	writing_____	answering_____
hearing_____	seeing_____	sitting_____
understanding____		using hands_____
walking_____		other (specify)_____

_____ _____
Interviewer Signature Date