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New Patient Intake – Pediatric (6-12 years)

Patient Demographic Information

Today's Date:__________________

First Name: ____________________ Middle Initial: ________ Last Name: ____________________ Title: ________

Nickname or Preferred Name: ____________________ Birthdate: ____________________ Age:________

Mother's Name:____________________ Father's Name:____________________

Street Address: ______________________________ City, State, Zip:____________________

Home Phone: ____________________ Parent's Cell/Work:____________________

Parent's Email: ____________________ Preferred Method of Communication?: □ Email □Phone

School:____________________ Lives with: □ Both Parents □ Mother □ Father □ Other:____________

Siblings (names and ages): ____

Emergency Contact: ____________________ Relationship: ____________ Phone: ____________

How did you hear about us?____

Health History Questionnaire

What are your child's most important health problems? List as many as you can in order of importance.

1) ____

2) ____

3) ____

4) ____

Does your child have a contagious disease at this time? Y/N If yes, what?____________________

Previous Illnesses

Please circle whether your child has had any of the following and indicate at what age:

Diphtheria	Chicken Pox	Rheumatic Fever	Mumps	German Measles (Rubella)
Scarlet Fever	Strep Throat	Measles	Other:____________________	

Ear Infections (How many times?__________) Tonsillitis (How many times?_____________)

Immunizations

Has your child had the following vaccines/immunizations?

Polio	Y N	Pertussis	Y N
Tetanus	Y N	Diptheria	Y N
Measles / Mumps / Rubella	Y N	Influenza	Y N

Any adverse vaccine reactions?   Y N

If yes, what was the reaction and with what immunization did it occur:____

Hospitalizations/Surgeries/Imaging

What hospitalizations, surgeries, or injuries has your child had?

____

____

Has your child ever had any of the following tests? If so, list when and where.

Electroencephalogram (EEG): ____

Psychological evaluation: ____

Hearing tests: ____

Speech / Language tests: ____

When was your child's last visit to a doctor's office, medical clinic or hospital and what was the reason?

____

Date of last physical exam:_______________   Date of last dental exam:________________

Date of last eye exam:__________________   Date of last blood work:________________

Please list the names and clinic names of your child's current health care providers including MDs, DOs, Naturopaths, Acupuncturists, Chiropractors or any other specialists.

____

____

____

Family History

Does anyone in your child's family have a history of any of the following? (**Please circle and say who**)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma/Cataracts
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay Fever	Hives	Headaches
Alcoholism	Infertility	Skin Disorder	Autoimmune Disease

Any other relevant family history?____

Allergies

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods?____

Any environmentals or chemicals?____

Breast fed?_____ For how long?__________ Formula?______ Milk, soy, other?_______________

Prescription Medications – List all prescription medications your child is currently taking. Please attach list if more space is needed.

Medication	Dosage	Prescribing Doctor Name	Related Medical Condition

Over-the-Counter Medications, Vitamins and Supplements -- (e.g. aspirin, multivitamin, decongestant, etc) Please attach list if more space is needed.

Brand Name	Supplement/Drug	Dosage	Related Medical Condition

Review of Systems – FOR THE FOLLOWING, PLEASE CIRCLE:

Y= a condition now **N**= never had **P**= significant problem in the past

MENTAL/EMOTIONAL

Mood Swings Y N P
Irritability Y N P
Hyperactivity Y N P
Introvert / Extrovert Y N P
Motion / car sickness Y N P
Anxiety / Nervousness Y N P
Cries Easily Y N P
Unusual fears Y N P
Sleep problems Y N P
Nightmares Y N P
Have a history of abuse? Y N P
Experienced a major trauma? Y N P

ENDOCRINE

Heat or cold intolerance? Y N P
Fatigue? Y N P
Excessive thirst? Y N P
Excessive hunger? Y N P
Low blood sugar? Y N P
High blood sugar? Y N P

SKIN

Rashes? Y N P
Eczema or hives? Y N P
Acne/boils? Y N P
Itching? Y N P

HEAD

Headaches? Y N P
Head injury? Y N P
Dizzy spells? Y N P
High fevers? Y N P

EYES

Impaired vision? Y N P
Tearing or dryness? Y N P
Eye pain or strain? Y N P

EARS

Ear aches? Y N P
Impaired hearing? Y N P

NOSE AND SINUS

Frequent colds? Y N P
Nose bleeds? Y N P
Stuffiness? Y N P
Hayfever? Y N P
Sinus problems? Y N P
Loss of smell? Y N P

MOUTH AND THROAT

Frequent sore throat? Y N P
Canker sores? Y N P

Breath odor? Y N P
Dental cavities? Y N P

RESPIRATORY
Cough? Y N P
Wheezing? Y N P
Asthma? Y N P
Bronchitis? Y N P

CARDIOVASCULAR
Heart disease? Y N P
Murmurs? Y N P

URINARY
Increased frequency of urination? Y N P
Bed wetting? Y N P

GASTROINTESTINAL
Belching or passing gas? Y N P
Stomach aches? Y N P
Constipation? Y N P
Diarrhea? Y N P
Bowel movements: how often? __________

MUSCULOSKELETAL
Joint pain or stiffness? Y N P
Muscle spasms or cramps? Y N P
Broken bones? Y N P

CARDIOVASCULAR
Anemia? Y N P
Easy bleeding or bruising? Y N P
Heart palpitations? Y N P

NEUROLOGIC
Seizures? Y N P

FEMALE REPRODUCTIVE
Has menstruation begun? Y N
Any symptoms?___________________________
____
Has breast development begun? Y N

MALE REPRODUCTIVE
Have both tests descended? Y N

Lifestyle Review

Please describe your child's typical daily food intake:

Breakfast:
____

Lunch:
____

Dinner:
____

Snacks:
____

Beverages:
____

Does your child sleep well? Yes / No Average hours/night:__________

Does your child spend time outdoors? Yes / No Average # of sick days per year:___________

Does your child watch T.V.? Yes / No Average hours per day:______________Hours per day on screens:______________________

Does your child exercise? Yes / No Describe activity and hours/week:____

Please list your child's hobbies and interests:____

Please list your child's predominant emotions:____

What causes stress for your child?____

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with Dr. Cole?