OSTEOPATHIC wellness center
158 Danbury Road, Suite 8, Ridgefield • 203.438.9915

INTAKE FORM -- CHILD MEDICAL AND HEALTH HISTORY

A. Identification

Child's Name:_____ **Age:**_____ **Birthdate:**____/____/_____ **Sex: M / F**
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Phone: (H)_____ **(C)**_____ **(W)**_____
Parent's email:_____ **How did you hear about us?**_____
Mother's Name:_____ **Father's Name:**_____
Parent's Family Status: Married / Divorced / Separated / Never Married (circle one)
Emergency Contact:_____ **Phone:**_____
Insurance Company and ID#:_____
(although we are out of network, we will provide you with an insurance receipt that you can submit to your insurance company for out-of-network benefits, if any)
Policy Holder's Name and Date of Birth:_____

B. Chief Complaint

Please list your child's major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation). Please rank in order of severity.

PROBLEM AND/OR SYMPTOM	DATE PROBLEM BEGAN

If you have seen other practitioners for these problems, indicate the results of these evaluations:

_____

_____

C. Family Medical History

Please indicate if <u>you, the parents</u> have had any of the following problems in the past. Please note years affected and if mother or father has particular problem.

Alcoholism		Depression		Herpes		Lyme Disease		Smoker	
Allergies		Diabetes		HIV		Mental Illness		Thyroid Disease	
Anemia		Digestive Disease		Hypoglycemia		Migraine Headache			
Arthritis		Drug Problems		Hepatitis		Multiple Sclerosis			
Asthma		Eating Disorder		High Blood Pressure		Prostate Disease			
Cancer		Eczema		Irritable Bowel		Rheumatic Fever			
Celiac Disease		Emphysema		Kidney Disease		Seizures			
Crohn's Disease		Heart Disease		Lupus/AutoImmune		Stomach/Intestinal Ulcers			

How many siblings does the child have?_____

Please list names, ages and any medical problems.

Name	Age	Medical Problems?

D. Prenatal History (For mother to complete)

Did you smoke during pregnancy? Yes / No Did you drink during pregnancy? Yes / No
Did you receive immunizations for flu or tetanus? Yes / No Did you receive rhogam? Yes / No
Did you have gestational diabetes? Yes / No Did you have pre-eclampsia (high blood pressure)? Yes / No
Did you have any serious illnesses? Yes / No
If so, please explain:_____
_____

E. Perinatal Period (For mother to complete)

Was your child born prematurely? Yes / No if so, how many weeks?_____
Did you experience any complications during delivery? Yes / No If so, please detail and note any medications you may have been given:_____
_____

Did your child need any special care after delivery? Yes / No If so, please explain:_____
_____

F. Early Childhood

Has your child been diagnosed with any chronic medical conditions to date? Yes / No If so, please list and note who diagnosed condition:

DIAGNOSIS	DOCTOR

Was your child breastfed? Yes / No If so, for how long?_____
Has your child frequently been treated with antibiotics for respiratory or ear/throat infections? Yes / No If so, approximately how many times? _____ Were there any delays in developmental milestones? Yes / No
If so, please explain:_____

H. Immunizations: Specify when received if known (or attach copy of immunization schedule):

IMMUNIZATION	DATES RECEIVED	IMMUNIZATION	DATE RECEIVED
Polio (oral / shot)		Hemophilus Influenza (HIB)	
Measles / Mumps / Rubella		Pnemococcus (PCV)	
Diphtheria/Pertussis/Tetanus			
Hepatitis B			
Chicken Pox			

I. Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

J. Current Medications / Supplements

Please write name, dosage and how often taken.

PRESCRIPTION/OVER THE COUNTER MEDICATIONS	SUPPLEMENTS

Please list any medications your child may have an allergy to and the type of reaction:_____

_____

K. Environment

Are there any pets in the house? Yes / No If yes, please list type(s)_____
Is the child's room carpeted? Yes / No Does any family member smoke in the house? Yes / No

Please complete primary care provider or pediatrician information:
Name:_____ Address:_____ Phone:_____

If you have a specialist, please complete:
Name:_____ Address:_____ Phone:_____
Specialty_____

L. Review of Systems

Please check next to the symptoms that your child has experienced over the past 6 months.

General		Skin		Eyes		Ears		Nose	
Fevers		Dryness		Eye Pain		Excessive Wax		Runny Nose	
Night Sweats		Rashes		Redness		Discharge		Nasal Discharge	
Insomnia		Itching		Discharge		Itching		Sneezing	
Frequent Colds/Flu		Nail Fungus		Itching		Ringing / Tinnitus		Frequent Bleeding	
Fatigue		Brittle Nails		Excessive Tearing		Decreased Hearing		Frequent Snoring	
				Dryness					
				Blurred Vision					
				Poor Night Vision					
Mouth		**Throat**		**Endocrine**		**Cardio/Pulmonary**		**Gastrointestinal**	
Oral Sores		Frequent Soreness		Intolerance to Heat		Shortness of Breath		Heartburn	
Funny Taste		Difficulty Swallowing		Intolerance to Cold		Palpitations		Bloating/Gas	
Bad Breath		Painful Swallowing		Shakiness		Cough		Nausea	
Coating on Tongue		Change in Voice		Fatigue		Chest Pain		Vomiting	
		Frequent Clearing Throat		Increased Appetite		Leg Cramps when Walking		Hemorrhoids	
		Hoarseness		Decreased Appetite		Leg Cramps at Night		Black or Dark Stools	
				Weight Gain/Loss		Varicose Veins		Blood in Stools	
				Sweat Easily		Lightheadedness		Constipation	
				Cold Hands/Feet		Passed Out		Diarrhea	
				Hair Loss/Thinning		Leg Swelling		Thin Stools	
				Excess Facial Hair					
				Eyebrows Thinning					
Neurological		**Mental/Emotional**		**Musculoskeletal**		**Genitourinary**		**Men Only**	
Numbness of a Limb		Anxiety		Joint Pain		Difficulty Urinating		Testicular Lumps	
Weakness of a Limb		Depression		Muscle Aches		Cloudy Urine		Penile Discharge	
Tension Headaches		Suicidal Thoughts		Back Pain		Involuntary Loss of Urine		Penile Lesions	
Migraine Headaches		Panic Attacks		Morning Stiffness		Frequent Urination		Impotence	
Room Spinning		Nervousness				Nighttime Urination		Breast Enlargement	
Head Trauma									
Memory Loss									

M. Diet Survey

Please check all the following statements, being careful to use the appropriate box related to the frequency of your child's personal habits.

Frequent = at least once per day Often = several times/week Occasional = once/week or less Seldom = once or twice/month or less
Never = almost total avoidance

	Frequently	Often	Occasional	Seldom	Never
Alcoholic Beverages					
Eat at Restaurants					
Eat at Fast Food Restaurants					
Pastries, Cookies, Candies, Ice Cream, Other Sweets					
Add Sugar to Coffee, Tea, Cereals, Other Foods					
Colas or Other Soft Drinks					
Instant Breakfasts, Pop Tarts, Doughnuts, Muffins					
Cold Breakfast Cereals					
Caffeine Drinks (Coffee, Tea, Cola, Chocolate)					
Deep Fried Food					
Margarine of any Type					
Whole Grain Hot Cereals (Oatmeal, Wheatena, etc.)					
Meat (Beef or Veal, Pork or Ham, Lamb, Liver)					
Chicken or Turkey – Regular or Free Range?					
Fresh Fish					
Processed Meat (Bologna, Turkey Roll, Sausage, etc.)					
Fresh Raw Fruit					
Fresh Vegetables, Raw or Cooked					
Salads					
Whole Grains or Whole Grain Breads					
White Bread or White Flour Products					
Beans and Legumes (Lentil, Kidney, Chickpea, etc.)					
Yogurt – Whole or Lowfat, Plain or Flavored (circle)					
Milk – Whole, Lowfat, or Skimmed (circle)					
Cheese					
Eggs – Regular or Free Range (circle)					
Salt					
Herbs, Fresh and Dried, or Spices					
Drink Adequate Water – Tap, Filtered, Bottled (circle)					
Eat Excessively if Bored or Depressed					
Swallow Food Before Chewing Well					
Hurried or Rushed Meals					
Stuff Yourself					
Read and Understand Food Labels					
Sneak or Hide Foods					
Adequate Fiber or Roughage in Diet					
Artificial Sweeteners (Saccharin, Nutrasweet, etc.)					
Shop at Health Food Stores					

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FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review this section and sign as acceptance below.

- Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to your visit to discuss.
- Cancellation Policy: I understand that there is a $75 charge for all missed or cancelled appointments with less than 24 hours notice (business day). This fee must be paid prior to scheduling another appointment.
- Minor Patients only: The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.
- There will be a $35 fee for returned checks.
- For your convenience, we also accept VISA and MasterCard.

I have read and understand my financial responsibilities as outlined above:

_____ _____

Patient's Signature or person signing on behalf of patient if he/she is a minor Date

_____

Patient's Printed Name

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CONSENT FORM & PRIVACY NOTICE

Consent for Treatment:

I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Consent for Contact:

With my consent, Osteopathic Wellness Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

Medical Release Authorization:

With my consent, Osteopathic Wellness Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

By signing this notice, I am consenting to Osteopathic Wellness Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Osteopathic Wellness Center may decline to provide treatment to me.

_____ _____

Patient's Signature or person signing on behalf of patient if he/she is a minor **Date**

_____

Patient's Printed Name

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PRIVACY POLICY

At Osteopathic Wellness Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us. We commit to protecting your privacy by abiding by the policies we have established and the terms of this notice. We reserve the right to change this notice, and if we make changes, we will provide patients with a revised notice.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern. There will be no retaliation against a patient for filing a complaint.

Your protected health information will be used to treat you and to carry out healthcare operations. We will not release your health information to other people, unless you specifically authorize us to do so, in writing.

The patient has the right to request the practice to restrict use and disclosure of protected health information.

The patient has the right to receive confidential communications of protected health information.

The patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Osteopathic Wellness Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Osteopathic Wellness Center may decline to provide treatment to me.

_____ _____

Patient's Signature or person signing on behalf of patient if he/she is a minor **Date**

_____

Patient's Printed Name