Carmen Hering D.O.
902 Santa Fe Avenue
Albany, CA 94706

NEW CHILD PATIENT INTAKE FORM

Today's Date: _____

Patient Name: _____ Date of Birth _____-_____-_____

Please print Age: _____

Please list primary caregiver(s) and relationship to child:

_____

_____

Number of households: _____

Address(s):

_____

_____

Home Phone(s): _____

Work Phone(s): _____

Cell Phone(s): _____

Email Address(s): _____

*Please circle the best place(s) to leave messages

Will you be submitting bills to an insurance carrier for reimbursement? ☐ Yes ☐ No

If yes: ☐ Health or ☐ Auto Insurance

Insurance Carrier: _____ Name on Policy: _____

Policy Holder DOB: _____-_____-_____

Emergency Contact: _____

Relationship: _____ Phone: _____

Who were you referred by? _____

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CHILD HEALTH QUESTIONNAIRE

Family History – Did any blood relative suffer any of the following?
Please indicate which family member: M = mother; F = father; B = brother; S = sister; MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather)

_____ ☐ Epilepsy	_____ ☐ Anemia	_____ ☐ Hepatitis
_____ ☐ Migraine	_____ ☐ Bleeding disorder	_____ ☐ Cancer
_____ ☐ Mental Illness	_____ ☐ Osteoporosis	_____ ☐ _____
_____ ☐ Glaucoma	_____ ☐ Arthritis	_____ ☐ _____
_____ ☐ Diabetes	_____ ☐ Heart disease	_____ ☐ _____
_____ ☐ Thyroid	_____ ☐ Hypertension	_____ ☐ _____
_____ ☐ Hayfever	_____ ☐ High cholesterol	_____ ☐ _____
_____ ☐ Asthma	_____ ☐ Alcoholism	

Allergies (drugs, foods, environmental):

_____

_____

Healthcare Practitioner(s) from whom you are *currently* receiving medical care and/ or prescriptions:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Past Surgical Procedure or Hospitalization	Date	Reason

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CHILD HEALTH QUESTIONNAIRE

MEDICAL HISTORY

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections
- ☐ Dizzy or fainting spells
- ☐ Low blood pressure
- ☐ Failing vision or eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds – recurrent
- ☐ Sinus trouble
- ☐ Sore throats – frequent
- ☐ Hoarseness – prolonged
- ☐ Hayfever /Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath
  - ☐on exertion ☐lying flat
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Leg pain when walking
- ☐ Varicose veins / Phelebitis
- ☐ Cold numb feet
- ☐ Change in appetite – recent
- ☐ Infants: difficulty breastfeeding
- ☐ Infants: frequent spitting-up
- ☐ Heartburn or Reflux
- ☐ Difficulty swallowing
- ☐ Nausea/ vomiting, frequent
- ☐ Abdominal Pain, frequent
- ☐ Gallbladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐Constipation
- ☐ Diverticulosis
- ☐ Crohn's / Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody or tarry stool
- ☐ Hemorrhoids ☐ Hernia
- ☐ Urination / Overactive bladder
  - ☐Bedwetting
  - ☐During night more than twice
  - ☐More than 8 times / 24 hrs
  - ☐Urgency to urinate
- ☐ Blood in urine ☐Kidney stones
- ☐ Urine infections – frequent
- ☐ Sexually active
  - ☐ # partners: _____
- ☐ Contraception _____
- ☐ STDs _____
- ☐ Weight loss ☐Gain – recent
- ☐ Anemia ☐Bruise easily
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Tics
- ☐ Numbness / tingling sensations
- ☐ Headaches – frequent
- ☐ Joint pain
- ☐ Back pain – recurrent
- ☐ Bone fracture / joint injury
- ☐ "Growing pains"
- ☐ Foot pain ☐Flat feet
- ☐ Rashes ☐Hives
- ☐ Psoriasis ☐Eczema
- ☐ Difficulty falling asleep
- ☐ Diffculty staying asleep
- ☐ Diffculty waking up
- ☐ Nightmares or terrors
- ☐ Depression ☐Nervousness
- ☐ Agitation ☐ Aggression
- ☐ Moodiness ☐Suicidal thoughts
- ☐ Phobias
- ☐ Feelings of worthlessness
- ☐ Rheumatic fever ☐Scarlet fever
- ☐ Chickenpox ☐Polio ☐Mumps
- ☐ Measles ☐German measles
- ☐ Tuberculosis
- ☐ Exercise _____
  _____
  # days/ wk _____
- ☐ After school activities _____
  _____
  # days/ wk _____
- ☐ Acupuncture/ tattoos
- ☐ Smoking: # /day _____
  # / wk _____
- ☐ Street drugs _____
  # days/ wk _____
- ☐ Alcohol: # drinks/ wk _____

FEMALES (*if applicable)*

Menstrual Flow:

- ☐ Regular
- ☐ Irregular
- ☐ Pain/Cramps

Age when menstruation began _____
Days of flow _____
Length of cycle _____
First day of last period _____
Number of Pregnancies _____
Abortions _____
Miscarriages _____
Live Births _____
Birth control method
_____
Date of last PAP test _____
☐ Normal ☐ Abnormal

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CHILD HEALTH QUESTIONNAIRE

BIRTH HISTORY

Number of previous pregnancies: ____
Number which were: Full term____ Preterm____ Abortion/miscarriage____ Living children ____

Please provide relevant information about conception, including information about biological parents:_____
_____

How was pregnancy?_____
_____

Who provided care during pregnancy and delivery? _____
_____

Where did labor and delivery occur? _____

If there was labor, please describe when, where and how it began: (spontaneously or induced)
_____
_____

How did labor progress? _____

What medications, is any were used? _____

How long was labor? _____ hours How long did pushing last? _____ hours

Were forceps or vacuum extraction used? _____

If caesarian birth was performed, please explain why: _____

Were there any complications? _____

How old was the child upon delivery? ____ weeks Weight: ____ lbs. ____ oz.

Were there any complications or concerns upon delivery? _____
_____

Describe early latch for breast and/ or bottle feeding, and any difficulties or complications:
_____

Did the child receive any medications or vaccines upon delivery? _____
_____

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CHILD HEALTH QUESTIONNAIRE

Please take the time to fill out the following to the best of your ability. It is sometimes difficult to discuss sensitive topics in the presence of your child; this form, therefore, provides us with an opportunity to be discreet. Please indicate if there any topics that you do not want discussed in front of your child.

What are your main reasons for seeking out help for your child?

What are your goals or expectations for treatment?

Please list past and present health issues, including dental:

Please list the use of antibiotics and other prescription medications and approximate dates:

Does your child use any over the counter medications? Please list:

Does your child get fevers? If so, do you use medication such as tylenol or motrin to control symptoms?

Please list any significant injuries, including head injuries, with approximate dates:

Please provide any more information about pregnancy and childbirth that was not included in the Birth History form:

Was your child breastfed? If so, for how long, and was supplemental formula needed?

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If not, were there feeding difficulties? Please describe:

Please describe your child as an infant, including sleep habits, temperament and feedings:

When did your child start solid foods and how was that?

Please describe how your child met developmental milestones, including difficulties, delays, accelerations, or skipping of certain stages: (sucking/ latching, grasping, lifting head, rolling over, sitting up, crawling, creeping, standing, walking, talking, self-feeding, toilet training)

Are there any food issues? (aversions to tastes or textures, cravings, intolerances)

Please describe your child's diet:

What are your child's favorite hobbies, interests, talents and activities?

Are there any activities or experiences that your child avoids?

With which hand does your child write, paint and eat?

How does your child respond to light, sound and touch?

Are there any grooming issues? (brushing, nail cutting, bathing, hair washing, dressing)

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How is sleep? (falling asleep, staying asleep, needing to co-sleep, heavy blanket/ no blanket, thrashing, sweating)

How would you describe your child's energy level? (steady, fluctuating, high, easily fatigued)

Is your child able to sit still for mealtimes and tasks, or does she need to move around?

In which situations is your child able to focus and concentrate?

How is your child during social interactions?

Are there any concerning behaviors or habits?

Please list the schools, groups, programs and classes that your child has attended or participated in up until now:

Which assessments or therapeutic modalities has your child used in the past? Please give approximate dates:

Thank you so much for your time and attention to these details. I look forward to our time together.

Carmen Hering, DO