Clinic

Pediatric Patient Demographics

Patient's Name: _____ Previous or Nickname: _____

Sex: ☐ Male ☐ Female Security Number: _____ - _____ - _____ Date of Birth: _____

Mailing Address: _____

City State Zip Code

Race: ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown ☐ Refuse to Report

PARENT/LEGAL GUARDIAN

Parent/Legal Guardian's Name: _____ ☐ **RESPONSIBLE FOR PAYMENT**

First Middle Last

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Mailing Address: _____

City State Zip Code

Home Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Employer: _____ Employer Address: _____

Work Phone #: (_____) _____ - _____

Parent/Legal Guardian's Name: _____ ☐ **RESPONSIBLE FOR PAYMENT**

First Middle Last

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Mailing Address: _____

City State Zip Code

Home Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Employer: _____ Employer Address: _____

Work Phone #: (_____) _____ - _____

INSURANCE INFORMATION

Primary Insurance Company's Name: _____ _____

Name as it Appears on the Card: _____ Cardholder's Date of Birth: _____

Cardholder's Social Security #: _____ - _____ - _____

Member ID #: _____ Group Name or #: _____

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Name: _____ **Date of Birth:** _____ **Todays Date:**_____

Patient Health History: Child

Your answers on this form will help your healthcare team obtain an accurate history of your child's medical concerns and conditions. Please do your best to complete all three pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Past and Current Medical Conditions: Please indicate with an **X** if your child has had the following:

SKIN CONDITION		**NEUROLOGICAL**	
Eczema/Psoriasis		Migraine or headaches	
EYES/EARS		Developmental delay	
Blindness		Learning Disability	
Hearing loss		Seizure	
RESPIRATORY		Traumatic brain injury/concussion	
Asthma		**GASTROINTESTINAL**	
Pneumonia		Irritable bowel /Ulcerative colitis/ Crohn's	
CARDIOVASCULAR		**MUSCULOSKELETAL**	
Hypertension		Back/neck injury	
High cholesterol		Arthritis	
Heart disease		**Urological/Renal**	
Heart murmur		Frequent Urinary Tract Infection	
ENDROCRINOLOGY		Kidney Stones	
Diabetes Type 1		Chronic kidney disease	
Diabetes Type II		**EMOTIONAL/BEHAVIORAL**	
		ADHD	
BLOOD CONDITION		Depression	
Anemia		Alcohol or Drug Abuse	
Bleeding/clotting problems		**OTHER:**	
		Thyroid Problems	

Current Medications (include prescriptions, over the counter, supplements, vitamins, and herbs):

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

Preferred Pharmacy:_____

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Reviewed/Revised 11/29/2016, 3/11/2019, 11/19/2020, 2/15/2023

Name: _____ **Date of Birth:** _____ **Todays Date:**_____

Allergies:

Source: (medications, pollens, food, animals, other)	Type of reaction:

Hospitalization and Surgical History (Include psychiatric):

Child was in the hospital or had surgery because:	Date	Location	Stayed Overnight?

Family History: Please indicate with an X if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Heart Disease				
High Blood Pressure				
Cancer				
Diabetes				
Asthma				
Mental Illness				
Migraine				
Eczema/Atopic Dermatitis				
Sudden death at age less than 50				
Genetic Disorders				
Other				

Health Maintenance:	**Yes**	**No**
Are all immunizations up to date?		
Dental visit in the past year?		
Vision check in the past year?		
Well Child check in the past year?		

Birth History: Please complete for all patients up to age 4	**Yes**	**No**
Did birth mother have Gestational Diabetes or Preeclampsia? (circle one) Any other pregnancy related illnesses? _____		
Did birth mother have an infection/STD/Group B Strep/Anemia/Medical treatment other than prenatal? (circle all that apply)		
Did birth mother have substance abuse during pregnancy?		
Vaginal Delivery or C-Section? (circle one) Breech?		
Admitted to NICU?		
Did the infant require hospitalization after mother left hospital?		
Gestational age at birth (weeks):	Maternal age:	
Birth weight:		

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Reviewed/Revised 11/29/2016, 3/11/2019, 11/19/2020, 2/15/2023

Name: _____ **Date of Birth:** _____ **Todays Date:**_____

Behavioral/Social History: Please complete for all patients age 2-17

	Yes	No	Not Applicable
Does your child exercise on a regular basis?			
Does your child feel satisfied with his/her current weight?			
Does your child like school?			
Does your child have any learning problems?			
Does your child have any suspensions, expulsions, and or behavior/attendance contracts from school this year or last year?			
Does your child have close friends he/she can talk to when stressed?			
Does your child have a job after school?			
Has your child ever had problems at home?			
Has anyone ever hurt your child physically, emotionally, or sexually?			
Do you worry about your child getting enough to eat?			
Have you ever had guns or weapons in the home?			
Has your child ever had trouble sleeping, depression, or suicidal thoughts?			
Has your child ever experienced/witnessed a traumatic event?			
Has your child ever been involved with social services or been in/out of home/foster care placement?			
Have you ever had individual, group, or family counseling/therapy?			
Does your child have little interest or pleasure doing things?			
Does your child feel bad about himself/herself?			
Does your child drink alcohol?			
Does your child use Meth or other street drugs?			
Does your child use recreational marijuana?			
Is your child experiencing issues related to sexual orientation?			
Is your child sexually active?			
Does your child use condoms or birth control?			
Does your child use tobacco products? (smoking, chew, snuff, other)			
Does your child use any holistic or alternative treatments? (acupuncture, massage, naturopathic remedies, medical marijuana, other)			

Clinic

Pediatric Patient Demographics

Secondary Insurance Company's Name: _____

Name as it Appears on the Card: _____Cardholder's Date of Birth: _____

Cardholder's Social Security #: _____ - _____ - _____

Member ID #: _____ Group Name or #: _____

WHO IS AUTHORIZED TO BRING YOUR CHILD FOR AN APPOINTMENT AT OUR OFFICE OTHER THAN PARENT/GUARDIAN?

I understand that if the status of any of the information below changes, it is my responsibility to inform the Clinic staff.

Name: _____

Relationship: _____

☐ I authorize you to leave a phone message with this person.

Home Phone #: (_____) _____ - _____
Home - May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____
Cell - May we leave a message? ☐ Yes ☐ No

Name: _____

Relationship: _____

☐ I authorize you to leave a phone message with this person.

Home Phone #: (_____) _____ - _____
Home - May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____
Cell - May we leave a message? ☐ Yes ☐ No

EMERGENCY CONTACT/IF NOT ALREADY LISTED

Name: _____ Relationship: _____

Home Phone #: (_____) _____ - _____May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Parent/Legal Guardian's Signature: _____

Parent/Legal Guardian's Printed Name: _____ _____

Date: _____/_____/_____

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Reviewed/Revised 03/23/2016, 11/04/2016, 3/11/2019