A Family Wellness Center
330 NE 102nd Ave.
Portland, OR 97220
(503) 252-9181

Pediatric Intake
10 Years of Age to 17 Years of Age

Name (First, Middle, Last)____
Date_________________
Age __________ Date of Birth _____________________________ Sex: M F
Mother or Guardian _________________________ Father or Guardian _________________________
Address ____ City ____________________________
State _________ Zip ___________ Telephone (Home) ________________________
Education ____________________ Hours per week ________ Hours of homework per week _______

Are you:
Next of kin or other to reach in an emergency _______________________________________
Relationship _________________ Address ____
Telephone (Home) ______________________ Telephone (Work) ______________________
How did you hear about the clinic? ____

Insurance Information

Primary Insurance:
Name of Insured(First, Middle, Last)________________________________Date of Birth __________
Relationship to Insured: ________________ Address: ______________________________________
ID#: ________________________________Policy #: ____
Group #: ____________________________Group Name: _____________ ______________________
Insurance Company: _________________________________ Telephone #: ______________________
Insurance Address: ____
How much is your deductible? ____________________ How much is your Copay? _______________

Secondary Insurance:
Name of Insured(First, Middle, Last)________________________________Date of Birth __________
Relationship to Insured: ________________ Address: ______________________________________
ID#: ________________________________ Policy #: _______________________________________
Group #: ____________________________ Group Name: _____________________________________
Insurance Company: _________________________________ Telephone #: ______________________
Insurance Address: ____
How much is your deductible? ____________________ How much is your Copay? _______________

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to A Family Wellness Center for services rendered.

___________________________________ ________________________
Patient's or Authorized Person's Signature **Date**

Health History Questionnaire

Holistic health care and preventative medicine are only possible when the physician has complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

When and where did you last receive medical or health care?
____

What was the reason? ____

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

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Family History

Check those applicable	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	________	________	________	________	________	________
Health G= good P= poor	________	________	________	________	________	________
Cancer	________	________	________	________	________	________
Diabetes	________	________	________	________	________	________
Heart Disease	________	________	________	________	________	________
High Blood Pressure	________	________	________	________	________	________
Stroke	________	________	________	________	________	________
Epilepsy	________	________	________	________	________	________
Mental Illness	________	________	________	________	________	________
Asthma,Hayfever,Hives	________	________	________	________	________	________
Anemia	________	________	________	________	________	________
Kidney Disease	________	________	________	________	________	________
Glaucoma	________	________	________	________	________	________
Tuberculosis	________	________	________	________	________	________
Age (at death)	________	________	________	________	________	________
Cause of death	________	________	________	________	________	________

Previous pregnancies by natural mother, miscarriages or complications: ___________________________
____
____

Mother's age at child's birth ________

Mother's health during pregnancy:

___ bleeding	___ hypertension	___ illness	___ cigarettes, alcohol, drugs
___ nausea	___ diabetes	___ thyroid problems	___ physical or emotional trauma

Birth History

Term: full ___ premature ___ late ___ weight at birth ______________
length of labor ________________ complications ____
As a baby, did your child have any of the following problems?

___ jaundice ___ diarrhea ___ birth defects ___ rashes
___ colic ___ fever ___ cerebral palsy ___ allergies
___ blue baby ___ seizures ___ birth injuries ___ other ___________________

Feeding: breast fed ___ how long? ___ formula ___ milk/soy ___
Age the child began: solid foods _____ sitting _____ crawling _____ walking _____
first words ___________________________________
Child's sleep patterns during the first year ____
____

Immunizations

___ measles ___ polio ___ MMR ___ small pox ___ diphtheria
___ mumps ___ DPT ___ tetanus ___ influenza
___ others ________________
Any adverse reactions to immunizations? (Please specify) ____________________________________
____

Childhood Illnesses

___ chicken pox ___ scarlet fever ___ bronchitis ___ tonsillitis, no. of times ____
___ measles ___ pneumonia ___ rubella ___ ear infections, no. of times ____
___ mumps ___ frequent cold ___ eczema ___ asthma
___ croup ___ other ____

Medications

	now	past		now	past		now	past
aspirin	___	___	antibiotics	___	___	decongestant	___	___
Tylenol	___	___	anti-histamine	___	___	ibuprofen	___	___
inhalers	___	___	asthma meds	___	___	topical steroids	___	___
__________	___	___	__________	___	___	___________	___	___

others

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Sleeping pills	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N			

Allergies to medicines____

X-Rays and Special Studies

	when	where	results
electroencephalogram			
psychological evaluation			
hearing			
speech/language			

Injuries/ Surgeries/ Hospitalizations

____

____

____

Review of Symptoms

Please circle: Y = a condition your child has now. N = never had. P = has had in the past.

General

Weight __________ Weight 1 year ago______ Max weight __________ When __________

Height __________ Fatigue Y P N

Skin

Rashes Y P N	Eczema, Hives Y P N	Itching Y P N
Acne Y P N	Color change Y P N	Lumps Y P N
Night sweats Y P N		

Head

Headache Y P N	Head injury Y P N

Eyes

Impaired vision Y P N	Glasses or contacts Y P N
Eye Pain Y P N	Tearing or dryness Y P N
Double vision Y P N	Glaucoma Y P N
Cataracts Y P N	

Ears

Impaired hearing Y P N	Ringing Y P N
Earache Y P N	Dizziness Y P N

Nose and Sinuses

Frequent colds Y P N	Nose bleeds Y P N
Stuffiness Y P N	Hay fever Y P N
Sinus problems Y P N	

Mouth and Throat

Frequent sore throat Y P N	Sore tongue Y P N
Gum problems Y P N	Hoarseness Y P N
Dental cavities Y P N	

Neck

Lumps Y P N	Swollen glands Y P N
Goiter Y P N	Pain or stiffness Y P N

Respiratory

Cough Y P N	Spitting up blood Y P N

Sputum	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N
Pneumonia	Y	P	N	Emphysema	Y	P	N
Pleurisy	Y	P	N	Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N	Tuberculosis	Y	P	N
Shortness of breath	Y	P	N	Short/breath lying down	Y	P	N
Short/breath at night	Y	P	N				

Cardiovascular

Heart disease	Y	P	N	Angina	Y	P	N
High blood pressure	Y	P	N	Murmurs	Y	P	N
Palpitations, fluttering	Y	P	N	Rheumatic fever	Y	P	N
Swelling in ankles	Y	P	N	Chest pain	Y	P	N

Gastrointestinal

Trouble swallowing	Y	P	N	Heartburn	Y	P	N
Change in thirst	Y	P	N	Change in appetite	Y	P	N
Nausea	Y	P	N	Vomiting	Y	P	N
Vomiting blood	Y	P	N				
Bowel movements	How often? _______________ Is this a change? Y N						
Blood in stool	Y	P	N	Belching, passing gas	Y	P	N
Jaundice (yellow skin)	Y	P	N	Liver disease	Y	P	N
Gall bladder disease	Y	P	N	Ulcer	Y	P	N
Hemorrhoids	Y	P	N				

Urinary

Pain on urination	Y	P	N	Increased frequency	Y	P	N
Frequency at night	Y	P	N	Inability to hold urine	Y	P	N
Frequent infections	Y	P	N	Kidney stones	Y	P	N

Female Reproductive

Average number of days	________			Length of cycle	________		
Regular cycles	Y	P	N	Bleeding between periods	Y	P	N
Pain during intercourse	Y	P	N	Painful menses	Y	P	N
Excessive flow	Y	P	N				

Breasts

Do you do self exam?	Y	P	N	Lumps	Y	P	N
Pain or tenderness	Y	P	N	Nipple discharge	Y	P	N

Male Reproductive

Hernias	Y	P	N	Discharge or sores	Y	P	N
Testicular pain	Y	P	N				

Muscoskeletal

Joint or pain stiffness	Y	P	N	Arthritis	Y	P	N
Broken bones	Y	P	N	Weakness	Y	P	N
Muscle spasms / cramps	Y	P	N				

Peripheral Vascular

Deep leg pain	Y	P	N	Cold hands or feet	Y	P	N
Varicose veins	Y	P	N	Thrombophlebitis	Y	P	N

Neurologic

Fainting	Y	P	N	Seizure	Y	P	N
Paralysis	Y	P	N	Muscle weakness	Y	P	N
Loss of memory	Y	P	N	Numbness	Y	P	N

Emotional

Depression	Y	P	N	Anxiety or nervousness	Y	P	N
Mood swings	Y	P	N	Tension	Y	P	N

Endocrine

Hypothyroid	Y	P	N	Heat or cold intolerance	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N

Blood

Anemia	Y	P	N	Easy bleeding	Y	P	N

Any other condition not mentioned? ____

____

Habits

What are you main interests and hobbies? ______________________________________

____

Do you exercise? Y N What forms? ______________________________

How often? ____

Do you eat three meals daily	Y	N	Awaken rested	Y	N
Average 6-8 hours sleep	Y	N	Sleep well	Y	N
Enjoy school	Y	N	Spend time outside	Y	N
Watch television	Y	N	How many hours/day (TV)	____	
Read	Y	N	How many hours/day (Read)	____	
Take vacations	Y	N			
Use recreational drugs	Y	N	Been treated for drug dependence	Y	N
Use alcoholic beverages	Y	N	Been treated for alcoholism	Y	N
Use tobacco	Y	N			

Diet

Please describe your child's typical daily diet: ____________________________________

____

____

____

____

Food intolerances (if known)____

____

____