Healthcare Excellence
Collaborative Health Specialty Services

Behavioral Health
Endocrinology | Diabetes
Osteopathic Manipulative Medicine
Sports Medicine
Physical Medicine & Rehabilitation

ONMM New Pediatric Patient Form (<15 yrs)

Date: _____

Name: _____
Last First Middle

Preferred Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to patient: _____

Primary Care Provider & Location: _____

Referring Provider & Specialty: _____

History of Problem

What can we help you with? _____

When did this start? _____

If known, what is the cause of the complaint today? _____

If the complaint is the result of an injury, please describe the incident and the date it occurred:

_____

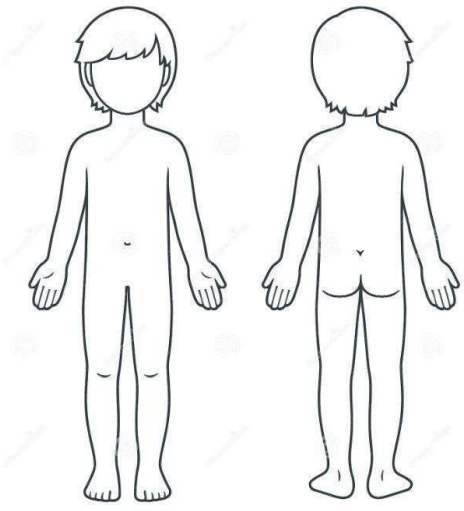
_____

Is there anything that makes the symptoms better? _____

_____

Is there anything that makes the symptoms worse? _____

_____



If the complaint is pain, what does it feel like?

Sharp Burning Crampy Achy

Intense Shooting Throbbing Dull

Pressure Other: _____

Please mark the areas that are impacted on the body map to the left. If possible, please have the patient do this.

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Please list any testing done for this complaint (for example: x- rays, CT, MRI, bloodwork, endoscopy)

Type of test	Date	Facility/Location	Result

Have any of these therapies been used? Did they make it better (B), worse (W), or no change (NC)?

	B	W	NC		B	W	NC
Heat				**Anti-inflammatories (Advil)**			
Ice				**Pain reliever (Tylenol)**			
Stretches/Exercises				**Muscle Relaxants**			
Massage				**Antibiotics**			
Electrical Stimulation/TENS				**Brace**			
Physical Therapy				**Surgery**			
Occupational Therapy				**Osteopathic Manipulation**			
Rest from activities				**Injection**			
Chiropractic				**Speech Therapy**			
Dental Intervention				**Lactation Consultant**			
Other:				**Other:**			

Please circle any other symptoms the patient has been having:

Constitutional: fevers, chills, night sweats, weight changes, change in activity level, general fussiness
Eyes: blurry vision, eye pain, eye discharge
ENMT: ear pain, congestion, hearing loss, sore throat, runny nose, allergies, sneezing
Cardiovascular: chest pain, rapid heart rate
Respiratory: cough, wheezing, rapid breathing, chest tightness
Gastrointestinal: abdominal pain, nausea, vomiting, diarrhea, constipation
Genitourinary: blood in urine, pain with urination, urinary frequency
Musculoskeletal: joint swelling, muscle aches
Skin: rash, excessive bruising, hives
Neurological: weakness, headache, dizziness, loss of consciousness
Psychiatric: anxiety, depression, insomnia *Endocrine:* increased thirst, cold/heat intolerance

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Medical History

Approximate date of most recent well-child exam: _____

Is the patient up to date on their vaccinations? Yes No

Does the patient have a developmental delay? Yes No

If they do have a developmental delay, what workup or treatments have been done? _____

_____

Are there any other providers the patient sees regularly? _____

_____

Were there any difficulties during the pregnancy or birth of this patient? _____

_____

Were there any difficulties during the newborn period of this patient's life? (i.e., poor latch) _____

_____

Please list any current or prior medical conditions and the treatment, if applicable:

Condition	Treatment	Current?
		[ ]
		[ ]
		[ ]
		[ ]
		[ ]

Please list any injuries (i.e., car accident, concussions) or hospitalizations and the date of each:

Injury/Reason for Hospitalization	Approximate Date	Hospital

Please list any surgeries or major dental procedures (including ear tubes, braces) and the date of each:

Surgery/Dental Procedure	Approximate Date	Location

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Please list any allergies to medications, food, or environment and the reaction to each:

_____

_____

Please list current prescription medications, over-the-counter medications, supplements, and doses:

_____ _____

_____

_____

Social History

Does the patient attend school or daycare? _____What grade? _____

What recreational activities or hobbies does the patient participate in? _____

_____

Who does the patient live with? _____

Please list any siblings and their ages: _____

_____

Does/did the patient have regular contact with someone who smokes?	Yes	No
Does/did the patient live in a home with alcohol or drug use?	Yes	No
Does the patient live in a safe home environment?	Yes	No
Are there any religious or cultural affiliations that may affect medical care?	Yes	No

Family Health History

Does the patient have any close family members (parents, siblings) with the following conditions?

Condition	Family Member	Condition	Family Member
Cancer	_____	Nerve/Muscle Disease	_____
Kidney disease	_____	Bleeding problems	_____
Stomach/bowel issues	_____	Autoimmune Disease	_____
Childhood Illness/Death	_____	Mental illness	_____
Diabetes	_____	Other	_____

Please describe information provided: _____

_____

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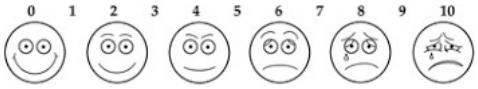
How severely is this impacting the patient's life?



Please list any activities the patient is unable to perform due to the complaint: _____

_____

Is there anything else you want to discuss with the doctor today? _____

How will you define treatment success? Complete resolution Decrease in symptoms

How did you hear about our clinic? Family/Friend Advertisement Medical Provider Other

Infants and Toddlers

Birth Weight: _____

How many times has the mother been pregnant? _____*How many live deliveries?* _____

Type of Delivery:

____Vaginal without intervention

____Vaginal with intervention (i.e., forceps, vacuum, induction of labor)

____Elective c-section (repeat c-section)

____Medically indicated c-section (emergent c-section, failure to progress, fetal distress)

Food sources (select all that apply):

____Breastmilk at breast

____Breastmilk in bottle

____Donor breastmilk

____Formula, type: _____

____Solid foods