

True North Pediatric Contact Information

Today's Date: _____

Date of Birth: _____

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street address

_____ City State Zip

PARENT'S NAMES: _____

Are parents: married single divorced living together separated other

LEGAL GAURDIAN: _____ RELATIONSHIP: _____

MOTHER'S HOME PHONE: _____ WORK: _____ CELL: _____

FATHER'S HOME PHONE: _____ WORK: _____ CELL: _____

EMAIL ADDRESS: _____

MOTHER'S OCCUPATION: _____

FATHER'S OCCUPATION: _____

CHILD'S SOCIAL SECURITY #: _____

GENDER: _____ AGE: _____ ETHNIC ORIGIN: _____

WHO LIVES AT HOME? (Please list name, ages and relationship)

PETS: _____

EMERGENCY CONTACT: (Name and Phone) _____

RELATIONSHIP TO PATIENT: _____

Although True North does not provide direct insurance billing, please be sure to give the receptionist your insurance card so that we can make a copy for any potential laboratory work that you may have done.

True North has my permission to leave detailed clinical information regarding my care on this phone line.

(Phone number)

(Signature)

Pediatric Comprehensive Health History

NAME: _____ Birth date: _____
Last First

(Please complete all sections as they apply to your child)

Current Problem: (please describe reason for your visit)

Current Healthcare Providers: (medical, psychiatric, counselors, or non traditional)

Names: _____ Dates: _____ Care Provided: _____

Name of school attending: _____ Current grade: _____

Past hospitalizations: (where, why, dates) _____

Current medications (include all prescribed, over the counter, herbal, homeopathic,

supplements) _____

Allergies: (medications, foods, animals, environmental)

Family Medical History

Check if your child or family members (parents, siblings, grandparents, aunts, uncles) have had any of the following:

Illness	Child	Family	Illness	Child	Family
Frequent ear infections			Heart murmur		
Frequent antibiotic use			Heart attack at < age 50		
Frequent Steroid use			High blood pressure		
Asthma / Wheezing			High cholesterol		
Pneumonia			Anemia		
Croup			Other blood problems		
Tuberculosis			High blood lead levels		
Hay fever / allergies			Thyroid problems		
Headaches			Diabetes		
Head injuries			Kidney / bladder problems		
Attention Deficit Disorder			Sexually transmitted disease		
Learning problems			Problems with bones		
Hyperactivity			Problems with muscles		
Developmental delay			Emotional disorders		
Autism			Depression		
Seizures			Anxiety		
Hearing problems			Bipolar disorder		
Dental problems			Other:		
Skin problems / eczema			Alcohol / substance abuse		
Problems with digestion			Suicide		
Gastric Reflux disease			Other Illnesses:		
Cancer: Type:					

Child's Prenatal and Birth History:

Place of Birth: _____ Planned Pregnancy Unplanned pregnancy
 Adopted
 Infertility problems Treatments to achieve pregnancy: _____
 Problems in the pregnancy (describe) _____
 Significant events or stressors in the pregnancy (describe) _____

Prenatal exposures: (mother exposed to these during pregnancy)

Alcohol Tobacco Substance use seafood ingestion: how often? _____
 Environmental toxins (circle) pesticides herbicides toxic waste mercury
 Other: _____

Vaginal birth Caesarean Section (reason) _____
 Premature birth (how early) _____ Over due (how long) _____

Medical interventions in labor/at birth: Induced Epidural Pain medications in labor
 Forceps Vacuum Umbilical cord around neck Breech General anesthesia at birth

Medical interventions after birth?

Resuscitation (needed help to breathe or other). IV's lab testing
 Newborn Intensive Care Nursery? How long? _____
 Prolonged separation after birth for baby? How long? _____

Other birth history: _____

- Post partum complications in mother (describe) _____
- Post partum depression in mother _____
- Problems feeding in baby (describe) _____

Day Care arrangements from infancy on: _____

Child's Sleep patterns:

- How long does it generally take to fall asleep? < 30 minutes _____ 30-60 minutes _____ 1 hour _____
- Does your child watch television in bed? yes no
- Does your child read in bed? yes no
- Does your child snore while sleeping? yes no
- Does your child have pauses or stop breathing while sleeping? yes no
- Does your child have a history of obstructive sleep apnea? yes no
- What time does your child go to bed during the week? _____
- What time does your child generally fall asleep at night? _____
- What time does your child get up during the week? _____ Weekend? _____
- Is your child sleepy during the day? yes no What time is the sleepest? _____
- Does your child take naps during the day? yes no Time of nap _____ How long _____
- Does your child ever fall asleep while eating or in other situations? yes no
- Does your child ever have vivid dreams upon falling asleep? yes no
- Does your child ever have nightmares? yes no
- Does your child have a history of night terrors? yes no
- Does your child complain of sore neck muscles in the morning? yes no
- Does your child have a history of sleep walking? yes no
- Where does your child currently sleep at night? _____
- What position does your child generally sleep in? stomach back side
- Is your child a restless sleeper? yes no
- How many pillows does your child use? _____
- Does your child seem to have enough energy? yes no

Nutritional Patterns

- Was your child: breast fed Age weaned _____
- Bottle fed What formula _____ Age off bottle _____
- Age when solids started? _____
- How is your child's appetite? Good Poor
- Is your child a picky eater? yes no
- Is your child on a special diet? yes no Explain: _____
- On the average, how many servings per day does your child eat from the following food groups?
- | | |
|---|-----------------------|
| _____ Fruits | _____ Sweets |
| _____ Vegetables | _____ processed foods |
| _____ Grains (bread, cereal, pasta, rice etc.) | _____ Fast Foods |
| _____ Proteins (meat, fish, eggs, nuts, nut butters, beans, lentils etc.) | |
| _____ Dairy | |
- _____ Amount of milk per day (cups: 8 oz = 1 cup)
- Type of milk (circle) Cow: whole, 2%, skim, Rice, Soy, Other: _____
- Does your child regularly drink or eat products containing caffeine? (coffee, tea, colas, chocolate)
- yes no How many servings per day on average? _____
- How many glasses of water does your child consume per day on average? _____

Any recent weight loss? yes no _____ pounds.
 Any recent weight gain? yes no _____ pounds.
 Is your child currently trying to lose weight? yes no
 Is your child currently trying to gain weight? yes no
 Does your child crave certain foods? yes no What? _____
 Does your child avoid certain foods? yes no What? _____

Elimination Patterns (urination and bowel movements)

Frequency of urinating (average times per day) _____ Pain with urination yes no
 Bedwetting? yes no Day time wetting? yes no
 Frequency of bowel movements: number per day _____ number per week _____
 Consistency of BM's: loose soft firm hard other: _____
 Color of BM's: _____
 Pain or straining with BM's: yes no
 Intestinal gas: normal amounts excessive foul smelling with pain
 Incontinence of BM's (accidents) yes no

Family Patterns

Any family members currently in treatment for a psychological or emotional problem? yes no
 Any recent changes in the family? (circle: separation, divorce, death, chronic illness in a family member, relocation to a new house or community, financial stress, new baby, other: _____)

Do you eat meals together as a family? Usually Seldom Never
 Does your family take time to play together? Usually Seldom Never
 How many hours does your child spend in day care per week? _____
 How many hours per week does your child spend in organized activities? _____
 Does your family attend religious services? Weekly Seldom Never
 Hours per day does of television viewing? _____
 Hours per day playing video or computer games? _____
 Hours per week playing with other children outside of school? _____
 Has your child ever been physically abused? yes no
 Sexually abused? yes no
 What is the most common type of discipline used in your family? _____

Does that kind of discipline usually work? yes no

Emotional Health

Is your child currently feeling sad or depressed? yes no
 Has your child thought about hurting (killing) self or others? yes no
 If so, has your child thought about how to do this? yes no
 Has your child ever had a suicide attempt? yes no
 Are there currently any family conflicts? yes no
 Describe briefly: _____

How does your child express anger? _____
 How does your child express frustration? _____
 How does your child express happiness? _____
 How does your child express sadness? _____

Does your child have any strong fears? yes no Describe: _____

Does your child have a problem separating from you? yes no

Does your child enjoy being alone? yes no

Does your child play well with other children? yes no

Can you talk easily with your child about problems? yes no

What kind of exercise does your child do? _____

How often? _____ How long? _____

What does your child like to do for fun? _____

What does your child enjoy doing the most? _____

How often does your child bathe or shower? _____

How often does your child wash his/her hands? _____

How often does your child brush his/her teeth? _____

HEALTH AND SAFETY ISSUES:	<u>Yes</u>	<u>No</u>
Are there guns in your house?		
If there are guns, are they locked?		
Is there a working smoke alarm in your house?		
Is the hot water temperature <125 degrees?		
Do you know how to do child resuscitation (CPR) or choking rescue?		
Are all medicines and poisons kept out of reach?		
Does your child use a car seat or seat belt all the time?		
Does your child wear a bicycle helmet all the time when riding a bicycle?		
Do you have rules/limits for television viewing/computer games?		
Is your child exposed to cigarette smoke?		
wood smoke?		
fumes from kerosene heaters?		
Do you live in a house built before 1965?		
Has your child been tested for lead exposure? Result:		
Do you use well water?		
Has your well been tested for fluoride?		
Does your child take fluoride supplements?		
Do you have pets in the home? What kind?		

Is there anything else you would like to say about your child that will help me to care for him or her?