North Canyon
MEDICAL CENTER

North Canyon Family Medicine Clinic

NEW PATIENT INTAKE FORM-Pediatric

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print clearly. All information is confidential.

Patient Name_____
Last First Middle
Date of Birth: _____/_____/_____ **SSN (Required)**: _____ **Male** _____ **Female** _____

Physical Address: _____**City**_____ **State**_____ **Zip**_____

Mailing Address: _____**City**_____ **State**_____ **Zip**_____
(If different from address above)

Home Phone: _____ **Cell Phone**: _____

Please list name of parent/head of household: _____

Parent/guarantor date of birth: _____**Phone number if different**: (_____) _____

Parents Employer: _____ **Work Phone**: (_____) _____

Person to contact in case of emergency? _____ **Phone:** _____

Relationship to patient: _____

INSURANCE INFORMATION:

Primary Insurance: _____
Name of Insured: _____ Birth-date of Insured: _____
Relationship to pt: _____ SSN of insured: _____
ID Number: _____Group #: _____
Amount of deductible: $_____ or Co-Pay: _____

Secondary Insurance: _____
Name of Insured: _____ Birth-date of Insured: _____
Relationship to pt: _____ SSN of insured: _____
ID Number: _____Group #: _____
Amount of deductible: $_____ or Co-Pay: _____

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CONSENT VERIFICATION:
Consent to use of answering machine and/or voicemail messaging: I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures. **I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing. I have filled out an Authorization to Release and/or Obtain Medical Information form.**

_____ _____
Signature of Patient/Patient Representative **Date (MM/DD/YYYY)**

Do you have a Consent for a Minor on File? Yes: ____ No: ____

Persons who can call and receive child's medical information other than Parent:

Name: **Relationship** **Phone#:**

_____ _____ _____

_____ _____ _____

Is your child adopted? ☐ No ☐ Yes If yes, at what age? _____

The child's parents are:
☐ Single ☐ Married ☐ Divorced ☐ Separated but not divorced
☐ Widowed ☐ Living together but not married

List your child's main health problems (or reasons for visiting the clinic).
☐ Routine checkup
☐ Immunizations (shots)
☐ A health problem (please specify)_____
☐ Switching doctors (last doctor _____)

How well do you feel your child acts or behaves?
☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Has your child ever been a patient in a hospital (please include surgeries)?
☐ No
☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When:**

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Is your child taking any prescription medicines?
☐ Yes - Please list the child's medicines below or ☐ I brought my child's medicines.
☐ No. My child does not take any prescription medicines.

Name of medicine	Dosage	How many pills or doses does your child take at-
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed

What pharmacy do you use for your child? _____City/State: _____

What over-the-counter medicines, does your child take regularly?
☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None. My child does not take any over-the-counter medicines regularly.

Does your child have any allergic reaction (bad effect) from any of the following? (Check all that apply.)
☐ Outside or Indoor allergies (for example: grass, pollen, cats …)
☐ Food Allergies (for example: peanuts, milk, wheat …)
☐ Medicine or shots (immunization). (Please list below.)
☐ No, my child has no allergies that I know of.

Medicine child is allergic to-	What happened when your child took the medicine?

Please list the previous Medical Providers your child has seen: _____
_____.

Please check any of the following medical problems that your child has ever had.

Ear infections	☐Yes ☐ No
Nose problems (sinus infections, nose bleeds)	☐Yes ☐ No
Eye problems (blurry vision, wears glasses)	☐Yes ☐ No
Hearing problems	☐Yes ☐ No
Mouth or throat problems (Strep throat, swallowing problems)	☐Yes ☐ No
Diarrhea (having frequent and runny bowel movements)	☐Yes ☐ No
Constipation (problems having a bowel movement)	☐Yes ☐ No
Vomiting	☐Yes ☐ No
Problems **urinating** (bed wetting, pain when urinating)	☐Yes ☐ No
Back problems (crooked back, back pain)	☐Yes ☐ No
Growing pains (bone or body pains due to growing)	☐Yes ☐ No

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Muscle and bone problems (weak muscles, pain in joints)	☐Yes ☐ No
Skin problems (acne, flaking skin, rashes, hives)	☐Yes ☐ No
Seizures	☐Yes ☐ No
ADD/ADHD (problems paying attention, sitting still)	☐Yes ☐ No
Sleeping problems (falling or staying asleep)	☐Yes ☐ No
Breathing problems (cough, asthma)	☐Yes ☐ No
Warts	☐Yes ☐ No
Jaundice (yellow skin)	☐Yes ☐ No

Has your child received immunizations (shots) in the past?
☐Yes
☐No

Does anyone in the household smoke?
☐Yes
☐No

The following questions are about the mother of the child during pregnancy and birth.

Were any of the following used during pregnancy?
☐ Cigarettes
☐ Alcohol
☐ Illegal drugs (which ones?
_____
☐ Prescription drugs (which ones?
_____
☐ None of the above

Did the mother have any of the following conditions or problems during pregnancy?
☐ Preeclampsia (high blood pressure)
☐ Emotional stress
☐ Unexpected bleeding or spotting
☐ Diabetes (sugar)
☐ Injury or serious illness
☐ Other _____

Was the birth:
☐ On the due date
☐ Before the due date (by how much_____
☐ After the due date (by how much_____
Was the birth: ☐ Vaginal ☐ C-Section

Were any of the following used?
☐ Pain medicine during birth (epidural)
☐ Tool to help pull baby out (forceps or vacuum)
☐ None

Were there any problems during the birth? ☐ Yes ☐ No
If yes, please explain: _____

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Was your and/or is the child breastfed? Yes ☐ No ☐ If yes, how long? _____

In the first 2 months after birth, did the child have:
☐ Jaundice (yellow skin)
☐ Colic (upset stomach, crying)
☐ Breathing problems
☐ Other _____
☐ None of the above

At what age did the child begin to crawl? _____
At what age did the child begin to sit up? _____
At what age did the child begin to walk? _____
At what age did the child get his/her first tooth? _____
At what age did the child began to say words (mama, dada)? _____

How would you rate your child's health in his or her first year of life?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Does the child go to school or daycare? ☐ Yes ☐ No If yes, what is the Day Care/Preschool/School name? _____

If your child goes to school or daycare, describe how your child acts in school or daycare. Please Check all that apply.

☐ Nervous, worried
☐ Hyper, restless, can't sit still
☐ Pushy, bullies' others
☐ Relaxed, calm
☐ Social, friendly
☐ Shy, withdrawn, keeps to self
☐ Gets angry easily
☐ Scared, fearful
☐ Moody
☐ Happy

How are your child's grades in school?
☐ Excellent ☐ OK ☐ Poor ☐ Does not go to school

About how much exercise does your child get every day?
☐ Less than 30 minutes ☐ 30 minutes to 1 hour ☐ Over 1 hour

About how many hours of TV does your child watch every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours is your child on a computer every day?
☐ Less than 1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours does your child spend outside every day?
☐ Less than1 hour ☐ 1-3 hours ☐ More than 3 hours

About how many hours are spent reading with your child every day?
☐ Less than 15 minutes ☐ 15-30 minutes ☐ 30 minutes to1 hour ☐ More than 1 hour

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What activities is your child involved in? _____
_____
_____.

☐ Too young to be involved in activities

Please list what your child typically eats and drinks in a day:
_____
_____
_____.

Check all the people that the child lives with:
☐ Mother
☐ Father
☐ Brothers (how many?____)
☐ Sisters (how many?_____)
☐ Other family members (list _____)
☐ Friends or other people (list_____)
☐ Animals ☐ Dogs (how many?_____) ☐ Cats (how many?_____)
☐ Other animals _____

Family Medical History:

Family Member	Medical Problems
Parents:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer? If yes; Type: _____ ☐ Heart problems ☐ Other: _____ +
	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer? If yes; Type: _____ ☐ Heart problems ☐ Other: _____

_____ _____
Signature of Patient/Patient Representative **Date (MM/DD/YYYY)**

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