North Canyon Medical Center
Orthopedic Clinic
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NORTH CANYON MEDICAL CENTER

NEW PATIENT INTAKE FORM-Pediatric

Patient Name____
First MI Last

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: _______________________________________

Person who can call and receive patient medical information: (For Confidentiality Purposes)

Name:	Relationship:	Contact Number:
________________________________	____________________	_______________________
_________________________________	____________________	_______________________

Primary Insurance: ____
Name of Insured: ______________________________ **Birth-date of Insured**: __________________

What are you being seen for today? (Only mark 2 body parts per office visit.)

O Neck	O Right Shoulder	O Left Wrist	O Right Knee	O Left Ankle
O Mid Back	O Left Shoulder	O Right Hand	O Left Knee	O Right Foot
O Low back	O Right Elbow	O Left Hand	O Right Calf/Leg	O Left Foot
O Ribs	O Left Elbow	O Right Hip/Thigh	O Left Calf/Leg	Other: _______
	O Right Wrist	O Left Hip/Thigh	O Right Ankle	____________

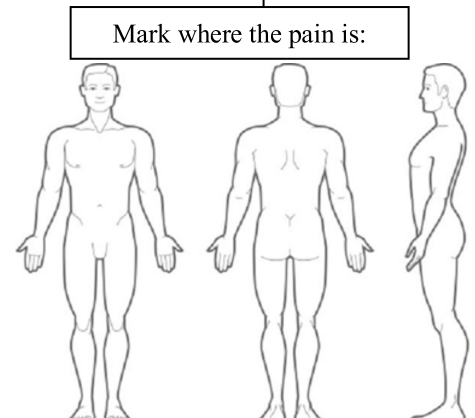
When Did the Problem First Begin?

____

Patient seen in the Emergency room for this problem? Y or N (When)

____

Mark where the pain is:



Have you had any of the following diagnostic tests for the problem you are being seen for today? (Please circle answer)

X-Ray MRI EMG/NCS Bone Scan CT Scan Bone Density Test

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:

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?

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) ☐ Diabetes (sugar)
☐ Emotional stress ☐ Injury or serious illness
☐ Unexpected bleeding or spotting ☐ 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: ____

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

What activities is your child involved in? ____
____

☐ Too young to be involved in activities

What medical problems do people in the child's family have?

Family Member	Medical Problems
Parents:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems ☐ Other: _____________________________________
Siblings:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems ☐ Other: _____________________________________

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Please sign here: ____ **Date**: _____________________

(Signature of parent/guarantor)