***New Patient Intake Form – Children 0-12***

***Please e-mail this completed form to:*** *reception@mtwholehealth.com*

|  |  |
| --- | --- |
| Child's name | Date of Birth |
|   |   |
| Today's Date | Gender |
|   |   |
| Parent/Guardian name | Relationship to child |
|   |   |
| Primary Phone (underline: home / cell / work) | Alternate Phone (underline: home / cell / work) |
|   |   |
| May we leave messages at these numbers? Yes ⃝ No ⃝ |
|
| Mailing Address |
|   |
| City State Zip |
|   |
| Email | Skype name |
|
| Emergency Contact name / relationship | Emergency Contact Phone |
|   |   |
| Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care: |
|   |
|   |
|   |
|   |
|   |
| How were you referred to us? |
|
|

Insurance Form

*If you are requesting Montana Whole Health to submit a claim to your insurer, please fill out the following form.*

|  |  |
| --- | --- |
| Patient Name: | Date of Birth: |
| Address: | Phone Number:*Please enter the preferred contact number*Cell:­Home:Work: |
| Primary Insurance Company: | Policy Number: |
| Name of Insured: | Insured’s DOB: |
| Insured’s Relationship to Patient: | Group Number: |
| Send Claim To (address on the back of the card): | Deductible:Individual:Family: |
| Insured’s Employer: |
| Policy Notes: |

**CONTEXT OF CARE OVERVIEW**

1. Why did you choose to come to Montana Whole Health?  What do you know about our approach?

2. What **three** expectations do you have from *this* visit to our clinic?  What **long-term** expectations do you have? What expectations do you have of me personally as your physician?

3. What is your present level of commitment to make lifestyle changes, if necessary, to treat your child’s condition? (Rate from 0-10, 10 being 100% committed)

 1 2 3 4 5 6 7 8 9 10

4. What potential obstacles do you foresee in making these lifestyle changes?

5. What do you believe are the biggest factors affecting your child’s health?

***Primary Concerns:*** *List in order of priority. Describe your concerns below if necessary.*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Concern****Example: Headaches* | ***Onset****Example: June 2010* | ***Frequency****Example: Daily* | ***Severity****Example: 5/10 or mild/mod/severe* |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

***Infant history:***

**Birthplace: Birth weight: Birth length:**

**Were there any of the following illnesses or problems during pregnancy?**

Rubella

High blood pressure

Excessive weight gain

Accident/injury

Bleeding

Gestational diabetes

Pre-eclampsia

Eclampsia

**Any other problems during the pregnancy? (**Please describe)

**At delivery was the baby:**

Breech?

Cesarean section?

VBAC

Resuscitated?

**Any other problems with birth or the first days of life?** (please describe)

**Did your baby deliver early? (**If so, by how many weeks?)

**Any problems with the baby’s health**? (Please describe)

**Breastfed?** (List duration)

**Formula fed?** (List duration) **Type of formula:**

**Any feeding problems?** (please describe)

***Developmental history:***

**Is your child easy to care for?**  **Difficult to care for?**

**Do you feel your child learns more quickly, average or more slowly than others?**

**Any problems with speech? Hearing? Vision?**

**How would you describe your child’s personality?**

**Any concerns about your child’s development?**

***Immunizations & Infections:***

**Is your child up-to-date on vaccines?**

**If missing, which ones?**

**Are you following an alternate vaccine schedule?** (Describe)

**Any adverse reactions to vaccines?**

**Has your child had any of the following illnesses:**

Chicken pox

Hepatitis

Positive test for TB

Measles

Mumps

Rubella

***Accident history:***

**Has your child had:**

Broken bones?

Severe burns?

Poisoning episodes?

Cuts needing stitches?

Frequent injuries or accident prone?

***Medical History and Current Symptoms.***

***Mark (x) those which apply to your child:***

|  |  |  |  |
| --- | --- | --- | --- |
| Past pneumonia |   | Chronic constipation |   |
| Seizures (past or present) |   | Heart problems |   |
| Urinary tract infection |   | Bleeding problems |   |
| Ear infections |   | Asthma |   |
| Chronic diarrhea |   | Anemia |   |
| Eczema |   | Frequent colds |   |
| Nightmares |   | Chronic cough |   |
| Dizzy spells |   | Frequent stomachaches |   |
| Joint pains or swelling |   | Poor appetite |   |
| Excessive thirst |   | Dark urine |   |
| Crossed eyes |   | Fatigue |   |
| Bed wetting after age 5 |   | Shortness of breath |   |

***Family Medical History:*** *List any diseases from above for each family member and age and cause of death if no longer alive.*

|  |  |  |
| --- | --- | --- |
| *Mother* | *Maternal Grandmother* | *Paternal Grandfather* |
| *Father* | *Paternal Grandmother* | *Paternal Grandfather* |
| *Siblings* |

***Surgeries & Hospitalizations:*** *Include when, where and injuries****.***

***Diet & Lifestyle:***

**What is your family’s religious/spiritual affiliation? How does this affect your health decisions?**

**Diet: What does your child typically eat in one day?**

**Breakfast:**

**Lunch:**

**Dinner:**

**Snacks:**

**Beverages:**

**What are the least healthful foods in your child’s diet:**

**Does your child drink:**

**Juice\_\_\_\_ Soda\_\_\_\_ Milk** (**note** if dairy alternative)**\_\_\_\_**

**Do you have any questions or concerns about your child’s diet?**

***Sleep & Elimination:***

**Bowel movements** (note frequency and consistency, if unusual):

**Urination/day or wet diapers/day:**

**Where/with whom/how does the child sleep?**

**Hours of sleep per day:**

**Naps:**

***Medications & Supplements –*** *attach your own list if desired.*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Medication*** *(Over the counter and prescription)* | ***Dosage & Frequency*** | ***Reason for taking*** | ***Cost/month*** |
| ***Supplements*** *(Including brand name)* | ***Dosage & Frequency*** | ***Reason for taking*** | ***Cost/month*** |

**Allergic reaction/intolerances to medications:** *Example: penicillin-hives*

**Allergic reaction/intolerances (foods, environment)** *Example: cow’s milk-bloating*

***Other:***

**What prior experiences have you had with alternative medicine?**