Live Oak Medicine

902 Santa Fe Avenue, Albany, CA 94706

Carmen Hering, DO

(510) 526-5256 • fax (510) 526-5547
www.carmenheringdo.com
liveoakmed@gmail.com

NEW CHILD PATIENT INTAKE FORM

Today's Date: ____________________

Patient Name: ____________________________________ Date of Birth ______-______-_______

Please print Age: _______

Please list primary caregiver(s) and relationship to child:

____

____

Number **of** households: ______ Number **in** households: ______

Address(s):

____

____

Home Phone(s): ____

Work Phone(s): ____

Cell Phone(s): ____

Email Address(s): ____

*Please circle the best place(s) to leave messages

Will you be submitting bills to an insurance carrier for reimbursement? ☐Yes ☐No

If yes: ☐Health or ☐Auto Insurance

Insurance Carrier: __________________________ Name on Policy: ________________________

Policy Holder DOB: ______-______-_______

Emergency Contact: ____

Relationship: _________________________ Phone: _________________________

Who were you referred by? ____

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CHILD HEALTH QUESTIONNAIRE (Page 1 of 6)

FAMILY HISTORY – Did any blood relative suffer any of the following?
Please indicate which family member: M = mother; F = father; B = brother; S = sister; MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather)

_________	☐	Epilepsy	_________	☐	Anemia	_________	☐	Hepatitis
_________	☐	Migraine	_________	☐	Bleeding disorder	_________	☐	Cancer
_________	☐	Mental Illness	_________	☐	Osteoporosis	_________	☐	_________________
_________	☐	Glaucoma	_________	☐	Arthritis	_________	☐	_________________
_________	☐	Diabetes	_________	☐	Heart disease	_________	☐	_________________
_________	☐	Thyroid	_________	☐	Hypertension	_________	☐	_________________
_________	☐	Hayfever	_________	☐	High cholesterol	_________	☐	_________________
_________	☐	Asthma	_________	☐	Alcoholism			

Allergies (drugs, foods, environmental):

____

____

Healthcare Practitioner(s) from whom you are *currently* receiving medical care and/ or prescriptions:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Past Surgical Procedure or Hospitalization	Date	Reason

CHILD HEALTH QUESTIONNAIRE

MEDICAL HISTORY

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections
- ☐ Dizzy or fainting spells
- ☐ Low blood pressure
- ☐ Failing vision or eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds – recurrent
- ☐ Sinus trouble
- ☐ Sore throats – frequent
- ☐ Hoarseness – prolonged
- ☐ Hayfever /Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath
  - ☐on exertion ☐lying flat
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Leg pain when walking
- ☐ Varicose veins / Phelebitis
- ☐ Cold numb feet
- ☐ Change in appetite – recent
- ☐ Infants: difficulty breastfeeding
- ☐ Infants: frequent spitting-up
- ☐ Heartburn or Reflux
- ☐ Difficulty swallowing
- ☐ Nausea/ vomiting, frequent
- ☐ Abdominal Pain, frequent
- ☐ Gallbladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐Constipation
- ☐ Diverticulosis
- ☐ Crohn's / Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody or tarry stool

- ☐ Hemorrhoids ☐ Hernia
- ☐ Urination / Overactive bladder
  - ☐Bedwetting
  - ☐During night more than twice
  - ☐More than 8 times / 24 hrs
  - ☐Urgency to urinate
- ☐ Blood in urine ☐Kidney stones
- ☐ Urine infections – frequent
- ☐ Sexually active
  - ☐ # partners: __________
- ☐ Contraception ________________
- ☐ STDs _________________________
- ☐ Weight loss ☐Gain – recent
- ☐ Anemia ☐Bruise easily
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Diabetes
- ☐ Seizures
- ☐ Tics
- ☐ Numbness / tingling sensations
- ☐ Headaches – frequent
- ☐ Joint pain
- ☐ Back pain – recurrent
- ☐ Bone fracture / joint injury
- ☐ "Growing pains"
- ☐ Foot pain ☐Flat feet
- ☐ Rashes ☐Hives
- ☐ Psoriasis ☐Eczema
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty waking up
- ☐ Nightmares or terrors
- ☐ Depression ☐Nervousness
- ☐ Agitation ☐ Aggression
- ☐ Moodiness ☐Suicidal thoughts
- ☐ Phobias
- ☐ Feelings of worthlessness

- ☐ Rheumatic fever ☐Scarlet fever
- ☐ Chickenpox ☐Polio ☐Mumps
- ☐ Measles ☐German measles
- ☐ Tuberculosis

- ☐ Exercise ______________________
  ____
  # days/ wk ___________________
- ☐ After school activities __________
  ____
  # days/ wk ___________________

- ☐ Acupuncture/ tattoos
- ☐ Smoking: # /day ______________
  # / wk ______________
- ☐ Street drugs __________________
  # days / wk ___________
- ☐ Alcohol: # drinks/ wk __________

FEMALES (*if applicable)*

Menstrual Flow:

- ☐ Regular
- ☐ Irregular
- ☐ Pain/Cramps

Age when menstruation began ______

Days of flow ______

Length of cycle ______

First day of last period _____________

Number of Pregnancies _____

Abortions ______

Miscarriages ______

Live Births ______

Birth control method

____

Date of last PAP test _______________

☐ Normal ☐ Abnormal

CHILD HEALTH QUESTIONNAIRE

BIRTH HISTORY

Number of previous pregnancies: ____
Number which were: Full term____ Preterm____ Abortion/miscarriage____ Living children ____

Please provide relevant information about conception, including information about biological parents:____
____

How was pregnancy?____
____

Who provided care during pregnancy and delivery? ______________________________________
____

Where did labor and delivery occur? ____

If there was labor, please describe when, where and how it began: (spontaneously or induced)
____
____

How did labor progress? ____

What medications, is any were used? ____

How long was labor? _____ hours How long did pushing last? _____ hours

Were forceps or vacuum extraction used? _______________________________________

If caesarian birth was performed, please explain why: ____________________________________

Were there any complications? ____

How old was the child upon delivery? ____ weeks Weight: ____ lbs. ____ oz.

Were there any complications or concerns upon delivery? _________________________________
____

Describe early latch for breast and/ or bottle feeding, and any difficulties or complications:
____

Did the child receive any medications or vaccines upon delivery? __________________________
____

CHILD HEALTH QUESTIONNAIRE

DEVELOPMENTAL HISTORY

Please take the time to fill out the following to the best of your ability. It is sometimes difficult to discuss sensitive topics in the presence of your child; this form, therefore, provides us with an opportunity to be discreet. Please indicate if there any topics that you do not want discussed in front of your child.

1. **What are your main reasons for seeking out help for your child?**

2. **What are your goals or expectations for treatment?**

3. **Please list past and present health issues, such as recurrent infections or major illnesses, including dental:**

4. **Please list the use of antibiotics and other prescription medications and approximate ages or dates:**

5. **Does your child use any over the counter medications? Please list:**

6. **Does your child get fevers? If so, do you use medication such as tylenol or motrin to control symptoms?**

7. **Please list any significant injuries, including head injuries, with approximate dates:**

8. **Please provide any more information about pregnancy and childbirth that was not included in the Birth History form:**

9. **Was your child breastfed? If so, for how long, and was supplemental formula needed?**
   If your child was not breastfed, were there feeding difficulties? Please describe:

10. **Please describe your child as an infant, including sleep habits, temperament and feedings:**

11. **When did your child start solid foods and how was that?**

12. **Please describe how your child met developmental milestones, including difficulties, delays, accelerations, or skipping of certain stages: (sucking/ latching, grasping, lifting head, rolling over, sitting up, crawling, creeping, standing, walking, talking, self-feeding, toilet training)**

13. **Are there any food issues? (aversions to tastes or textures, cravings, intolerances)**

14. **Please describe your child's diet:**

15. **What are your child's favorite hobbies, interests, talents and activities?**

16. **Are there any activities or experiences that your child avoids?**

17. **With which hand does your child write, paint and eat?**

18. **How does your child respond to light, sound and touch?**

19. **Are there any grooming issues? (brushing, nail cutting, bathing, hair washing, dressing)**

20. **How is sleep? (falling asleep, staying asleep, needing to co-sleep, heavy blanket/ no blanket, thrashing, sweating)**

21. **How would you describe your child's energy level? (steady, fluctuating, high, easily fatigued)**

22. **Is your child able to sit still for mealtimes and tasks, or does she need to move around?**

23. **In which situations is your child able to focus and concentrate?**

24. **How is your child during social interactions?**

25. **Are there any concerning behaviors or habits?**

26. **Please list the schools, groups, programs and classes that your child has attended or participated in up until now:**

27. **Which assessments or therapeutic modalities has your child used in the past? Please give approximate dates:**

Thank you so much for your time and attention to these details. I look forward to our time together.

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OFFICE POLICIES

Welcome: To help you get acquainted with our office, we have prepared a few words about our policies. If you have any questions or suggestions, please feel free to discuss these with us at any time. Please read and sign each form; this indicates to us that you have read and understand our guidelines.

Your Appointment: Appointments can be made either online or by phone. Every effort is made to examine newborn infants as soon as possible after birth. Special priority is also given to those with acute injuries or medical conditions and pregnant or post-partum women. Your appointment is time set aside for you to see your doctor. Note that we have a two-business day cancellation policy. If you cancel an appointment less than two-business days prior to its scheduled time, you will be billed *the full* visit fee. Appointments may be cancelled online or by phone (please see our online instruction form). A message may be left on our voicemail at any time. The earlier you can inform us of a change in your plans, the sooner we can give your appointment to someone else in need.

Fragrances: Some of our patients are allergic to environmental pollutants, such as perfumes, scented body and hair care products. We would appreciate it if you refrain from wearing these to our office.

Cell phones: We make every effort to cultivate a tranquil, healing environment for our patients. Please refrain from using cell phones in the building and silence any ringers and alarms. Emergent calls can be taken outside the building. We appreciate your understanding.

Fees & Payment: *We require payment for services at the time they are provided.* We supply a standard itemized receipt, also known as a "superbill", which you may submit to your insurance company in case you qualify for reimbursement.

In the case of minors, the parent or guardian who accompanies the minor is responsible for payment, even if the parents are separated or divorced and the person responsible for paying medical bills is not present at the time of the visit. If your check is returned from the bank, we will charge a $30.00 "return check" fee. For patients requesting photocopies of their medical records, a $25 copying fee applies.

Children: Children must be supervised by their caretaker. For their own safety, please do not allow children to roam about in other rooms or to touch electrical objects.

Thank you for taking the time to read this policy sheet. If you have any questions about this policy, please ask them now. We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery; however, we cannot guarantee any specific result.

I have read and understand the above policy and agree to it.

Patient/Guardian Signature: ____ Date: __________________

(Print Name of Patient/Guardian ______________________________________

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MEDICAL RELEASE FORM

Today's Date: _______________

Patient Name: _____________________________________ Date of Birth ______-______-_______
Please print

1. Permission to release information to Insurance Carriers:

I give permission to this office to release medical information to my health or automobile insurance company.

Patient/Guardian Signature: ____ _____________________
Date

____
(Print Name of Patient/Guardian)

☐ Please contact me when you receive requests for information from my insurance carrier.

2. Permission to Share Information with Health providers:

I give permission to this office to share my medical information with my other health providers so that they may coordinate my care.

Patient/Guardian Signature: ____ _____________________
Date

____
(Print Name of Patient/Guardian)

☐ Please contact me before sharing any information with my other health providers.

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area. I further acknowledge that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient: ______________________________

Patient/Guardian Signature: ____ ____________________
Date

____
(Print Name of Patient/Guardian)

Address: ____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

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OFFICE PATIENT PRIVACY POLICY

In order to protect sensitive personal and medical information, we have instituted a number of measures aimed at maintaining your privacy. The National Institutes of Health have newly developed the *Health Insurance Portability and Accountability Act* (HIPAA), which requires that every medical provider makes a privacy policy available to their patients. This effort is set in place to maintain privacy of patient information in an era of high technology and data-laden medical systems. The following is the policy for patients of this office regarding patient privacy and confidentiality of information collected and stored in this office:

1. For payments and scheduling, our office manager will assist you.

2. An information sheet with demographic data, insurance information, consent for treatment and medical disclosure will be completed by every patient as part of her/his record. A copy of this sheet will be available to our office manager for billing purposes.

3. All superbills for office visits will be shared with the office manager in order to process insurance claims and record business transactions for tax purposes.

4. Any paper trash with patient information will be shredded prior to discarding it.

5. Employees and staff are required to sign a confidentiality agreement regarding any information they are exposed to in the office setting, which is not to be discussed or revealed to any person(s)/business(es) outside of the office setting without prior written consent by the patient/legal guardian.

6. Medical release forms are required to be signed by the individual or parent/guardian in order to release any medical information to themselves, medical offices, insurance companies, or to any other desired location. A copying charge may apply for extensive record copying.

7. All medical related conversations will occur in private.

8. All papers related to patient care will be stored in locked cabinets when not in use, where only authorized medical and administrative staff has access to them.

9. Any breach of confidentiality must be submitted in writing to Carmen Hering, D.O. for proper action to be taken to amend the situation and/or policy.

I have read and understand the above Patient Privacy Policy.

Patient/Guardian Signature: ____________________________________ ____________________
Date

(Print Name of Patient/Guardian) ______________________________