Dr. Vanessa Newman, DO

Osteopathic Physician

Acorn Community Clinic

New Child Intake Form

Welcome to our practice!

Today's Date: _____

Patient Name: _____ Date of Birth _____ Age: _____

Preferred Gender Pronouns: _____

Primary caregiver(s) names, and relationship to child: _____

_____

Address(s): _____

_____

Home Phone(s): _____ Cell Phone(s): _____

Email Address(s): _____

Best place(s) to leave messages: □ Home □Cell

Number in household: _____ Siblings ages (as applicable): _____

Grade in school/daycare, as applicable_____

Will you be submitting bills to an insurance carrier for reimbursement? □Yes □N0;

If yes: □Health or □Auto Insurance

Insurance Carrier: _____ Name on Policy: _____

Policy Holder DOB: _____-_____-_____

Please indicate if you receive coverage through:

□ Disability □ Work Comp □ Medicare

Emergency Contact: _____

Relationship: _____ Phone: _____

Who were your referred by: _____

Reason for your/child's visit today (There will be space to expand upon this later in this document, and certainly during our appointment):

_____

_____

_____

_____

Was there an inciting event, or anything different in your/child's life, 6-12 months before this concern began?

_____

_____

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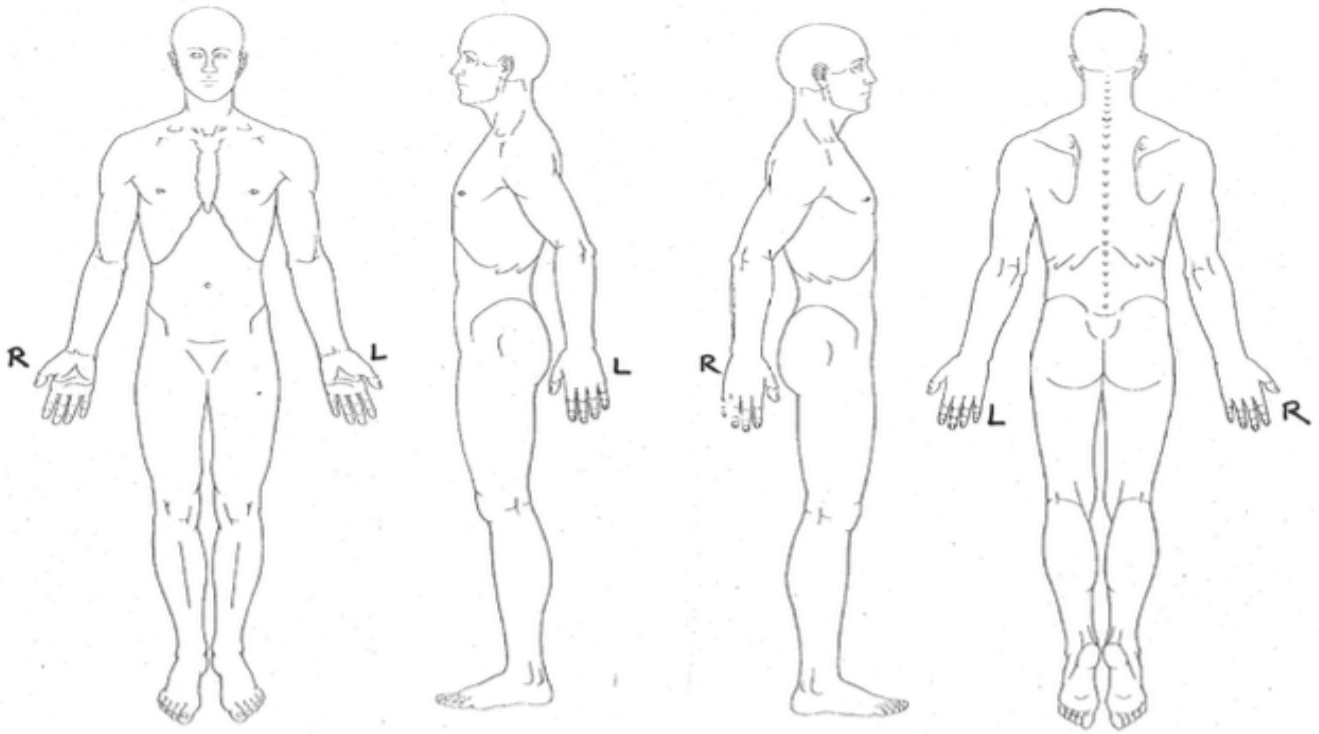

Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.

Family History – Did/does any blood relative suffer any of the following? (Please indicate the following: M = mother; F = father; B = brother; S = sister; MGM = maternal grandmother; MGF = maternal grandfather; PGM = paternal grandmother; PGF = paternal grandfather)

_____ □ Epilepsy	_____ □ Asthma	_____ □ High cholesterol
_____ □ Migraine	_____ □ Anemia	_____ □ Alcoholism
_____ □ Mental Illness	_____ □ Bleeds easily	_____ □ Hepatitis
_____ □ Glaucoma	_____ □ Osteoporosis	_____ □ Cancer
_____ □ Diabetes	_____ □ Arthritis	_____ □ _____
_____ □ Thyroid	_____ □ Heart disease	_____ □ _____
_____ □ Hay fever	_____ □ Hypertension	_____ □ _____

Allergies (drugs, foods, environmental):

_____

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Primary Care Physician and other healthcare practitioner(s) from whom you/your child are *currently* receiving medical care:

Physician/ Practitioner	Condition being treated	Medications/Supplements

Please list all major medical problems/illnesses, surgeries, including major dental work and hospitalizations (indicate year/age, may continue on back as needed)

Year/age	

Describe all car accidents, injuries, head injury, falls, fractures or broken bones (include year/age occurred, may continue on back):

Year/age	

CHILD'S 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 if any, were used? _____

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

Were forceps or vacuum extraction used? _____

If cesarian birth was preformed, please explain why: _____

Were there any complications during labor? _____

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?

_____

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MEDICAL HISTORY

□ Decreased hearing
□ Ringing in ear
□ Ear infections
□ Dizzy or fainting spells
□ 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
□ High blood pressure
□ Heart murmur
□ Swollen ankles
□ Irregular pulse
□ Palpitations
□ Leg pain when walking
□ Varicose veins / Phlebitis
□ Cold numb feet
□ Loss of appetite - recent
□ Eating disorder
□ Difficulty swallowing
□ Heartburn
□ Peptic ulcer
□ Persistent Nausea / vomiting
□ Abdominal Pain - chronic
□ Gallbladder trouble
□ Jaundice / Hepatitis

□ Diarrhea □Constipation
□ Diverticulosis □ Crohn's / Colitis
□ Inflammatory bowel syndrome
□ Bloody or tarry stool
□ Hemorrhoids
□ Hernia
□ Urination / Overactive bladder
□ Bedwetting
□ Overnight more than twice
□ Urgency to urinate
□ More than 8 times / 24 hrs
□ Blood in urine
□ Kidney stones
□ Urine infections- frequent
□ Sexually active
□ Number of partners___
□ Contraception_____
□ STDs_____
□ Weight loss □ Gain – recent
□ Anemia □ Bruise easily
□ Blood transfusions
□ Cancer
□ Chronic fatigue
□ Diabetes
□ Thyroid disease
□ Seizures □ Stroke
□ Tics
□ Numbness / tingling sensations
□ Headaches – frequent
□ Joint pain
□ Back pain – recurrent
□ Bone fracture / joint injury
□ "Growing pains"
□ Foot pain □ Flat feet

□ Unusual moles □ Rashes □ Hives
□ Psoriasis □ Eczema
□ Any type of sleeping difficulty
□ Snoring/Mouth breathing
□ Depression □ Nervousness
□ Agitation □ Memory loss
□ Moodiness □ Phobias
□ Suicidal thought □ Mental illness
□ Feelings of worthlessness
□ Rheumatic fever
□ Scarlet fever □ Mumps
□ Chickenpox □ Polio
□ Measles □ German measles
□ Tuberculosis □ Herpes
□ AIDS / HIV
□ Acupuncture / tattoos
□ Exercise: _____
_____
days/week _____
□ After school Activities:
_____
_____
□ Smoking: #/day_____
#/wk _____
□ Street drugs _____
#days/wk_____
□ Alcohol: # drinks/wk_____

FEMALES *Please complete:*

Menstrual Flow:
Age of onset _____
□ Regular □ Irregular
□ Pain/Cramps
Days of flow _____
Length of cycle _____

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Date of 1st day of last period_____

Number of Pregnancies _____ □ Normal □ Abnorma

Date of last PAP test _____

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 (feel free to use the backside of this sheet):**

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 do they 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:**

Routine labs: date of most recent: _____

Indicate any abnormal results: _____

Previous imaging/X-Rays: (Body Region and Reason for test)

X-ray _____

MRI _____

CT Scan _____

Ultrasound _____

Other procedures: _____

Thank you so much for your time and attention to these details. I look forward to our time together. **Vanessa Newman, DO**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my health. I also authorize the healthcare providers to perform the necessary health care services I may need, including Osteopathic Manipulation.

Signature_____Date_____

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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 *one-half* the 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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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

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEDGEMENT 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/Guardian Signature: _____Date_____

_____

Print Name of Patient/Guardian

Patient SIgnature: _____Date_____

_____

Print Name of Patient