



Maria Coffman, D.O.
Osteopathic Physician

HandsOnHealthDO.com p: 573-256-1331 f: 573-256-1332 Doctor's Park, 201 West Broadway, Suite 2E Columbia, MO 65203

NEW PEDIATRIC PATIENT FORM- Ages 0-3 years

Name: _____
 (First) (Middle) (Last)

Date of birth (MM/DD/YYYY): ____/____/____ Age: ____ Male Female

Reason for visit _____

When did symptoms start? _____

Primary care practitioner _____

Other practitioners _____

SOCIAL HISTORY

Mom's name _____

Dad's name _____

Names of siblings None

Date of birth

Patient lives with Mother Father Step-Mother Step-Father Other _____

Parent's marital status: Single Married Separated Divorced Widowed Re-married

Mother's occupation: _____

Father's occupation: _____

Patient's ethnicity/cultural background: _____

School/daycare: _____ Grade: _____

Activities and interests: _____

ENVIRONMENTAL HISTORY

Home tested for lead? No Yes Not sure

Home tested for radon? No Yes Not sure

What is the source of your drinking water?

Well City Bottled Filtered, Type: _____

Are solvents, disinfectant chemicals or pesticides used in the home? No Yes Not sure

Do you watch TV, or use a computer or video game system? No Yes Time per day? _____

Do you have any concerns regarding health and environment? _____

Patient and Relatives (children, parents, siblings, grandparents)

	Patient	Relative	Comments			
<i>Birth defects</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Anemia/ blood problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Premature births</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Cancer</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Ear infections</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Diabetes</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hearing problems</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Thyroid problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Dental fillings</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Growth problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Crown or Bridge</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Other endocrine/ gland issues</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Dental Braces/splints</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Growing pains/ bone problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Clenching or grinding</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Scoliosis</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Eye/vision problems</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Neck or back pain</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Asthma</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Arthritis/ joint problem</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Allergies</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Chronic pain</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Sinus/ nasal</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Muscular problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Skin rashes/eczema</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Swallowing problem</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Pneumonia</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Coordination problem</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Sore throats</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Headaches</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Heart problems</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Seizures</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>High blood pressure</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Memory problems/ Alzheimer's</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>High cholesterol</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Alcohol abuse</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Chronic diarrhea</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Substance abuse</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Chronic constipation</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>School problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Chronic abdominal pain</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Learning problems</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Reflux/nausea/ vomiting</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Depression or mental illness</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Urinary infections/ kidney disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<i>Social difficulty</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>STD</i>	<input type="checkbox"/>	<input type="checkbox"/>	_____			

PAST MEDICAL HISTORY

Allergies (Medications, Food, Environmental):

None known *See attached page

Reaction: _____

Reaction: _____

Medications, including vitamins, herbs, and supplements:
Please include name, brand, and dose:

None

*See attached page

Immunizations Up-to-Date? Yes No, because _____

Current and past illness _____

Injuries, falls, accidents _____

Sutures/stitches _____

Head injuries (Ex. concussions)? _____

Fractures? _____

Hospitalizations? _____

Surgeries? _____

Pregnancy: Mom's age during pregnancy: _____ Father's age _____

Mother's general health _____

Father's general health _____

For the mother during pregnancy:

Medications _____

Hospitalizations _____

Injuries _____

Illness _____

Change in home environment (moved, job change, marital status change) _____

Birth: Place of birth: City, State _____ Home Hospital _____ Clinic _____

Premature: _____ wks Full term: _____ wks Post-term: _____ wks

Birth weight: _____ APGAR scores _____ Bruising/Molding: No Yes

Was delivery induced? No Yes, because _____ Pitocin?

Cesarean? No Yes, because _____

For vaginal birth- How long was labor? _____

How long was pushing phase? <20 min 20-60 min >60 min

Forceps or suction? No Yes _____

Birth: Baby's presentation (circle): Normal Breech Face-up Other: _____

Complications with baby? No Yes _____

Complications with mother? No Yes _____

Infancy: Torticollis? No Yes (left/ right) Blocked tear duct? No Yes (left/ right)

Breastfed? No Yes, until _____ Pacifier? No Yes, until _____

Formula? No Yes, type: _____

Intolerances to breastmilk, formula or food? No Yes _____

How long and how often does baby nurse? _____

Difficulty breastfeeding? painful for Mom, poor latch-on, falls asleep, low milk supply _____

Development: Crawled before walking? No Yes Age walked: _____

First words at approximately _____ months

Speech or Physical therapy? No Yes _____

DIETARY HISTORY

Typical breakfasts: _____

Typical lunches: _____

Typical dinners: _____

Typical snacks and drinks _____

Preferences: (circle) Salty Sweet Crunchy Creamy Spicy Light-not filling

Foods avoided and why: _____

SLEEP HISTORY

What time do you typically fall asleep? _____ What time do you typically wake up? _____

Do you fall asleep easily? No Yes Do you awaken during your sleep? No Yes Time? _____

Whom may I thank for your referral? _____

REGISTRATION INFORMATION**Please Print**

Name First _____ MI _____ Last _____

Social Security _____ - _____ - _____ **Marital Status** S M D W (circle one)**Date of Birth** _____ / _____ / _____ **Age** _____ **Sex** Male ___ or Female ___
Month Day Year

Street Address _____

City _____ State _____ Zip _____ - _____

Phone Numbers: 1st # to call (____) _____ - _____ Home - Work - Cell - Other - Message
2nd # to call (____) _____ - _____ Home - Work - Cell - Other - Message
3rd # to call (____) _____ - _____ Home - Work - Cell - Other - Message**Email Address** _____**If patient is a minor, Parent's Names:** Mother _____ Father _____**Employer** _____

Address _____ City _____ State _____ Zip _____

Person Referring _____

Address _____ City _____ State _____ Zip _____

Phone # (____) _____ - _____

Preferred Pharmacy _____ **Phone** (____) _____ - _____**IN CASE OF EMERGENCY NOTIFY** _____

Relationship _____ Phone (____) _____ - _____

I, the undersigned, do hereby agree and give my consent for Hands On Health, Maria Coffman D.O. to furnish all treatment and medical care considered necessary. Payment will be made at time of service. Any account not paid under agreement will be considered in default and will be referred for proper collection. All expenses incurred from such action shall be the responsibility of the patient/responsible party including, but not limited to, collection charges, legal fees, etc.

Patient or Other Responsible Party's Signature_____
Today's Date

Acknowledgement of Hands On Health HIPAA Policy

I have reviewed Hands On Health Osteopathic Medicine HIPAA privacy policy which is summarized as follows:

- a. Right to access/copy private health information (PHI)
- b. Right to amend PHI
- c. Right to restrict use or disclosure
- d. Right to confidential communications
- e. Right to an accounting of disclosures
- f. Right to file a complaint

I am aware that the complete HIPAA policy for Hands On Health may also be accessed on website at HandsOnHealthDO.com or in the office.

PATIENT: Self Child

PATIENT'S NAME: _____

PATIENT'S DOB: ____/____/____

PARENT'S/GUARDIAN'S NAME if patient is < 18 years-old: _____

SIGNATURE: _____ DATE: _____