Maria Coffman, D.O.
Osteopathic Physician

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NEW PEDIATRIC PATIENT FORM- Ages 4-18 years

Name: ____
(First) (Middle) (Last)

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

Reason for visit and duration of symptoms____

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

PAST MEDICAL HISTORY

Allergies (Medications, Food, Environmental): ☐ None known ☐ *See attached page

____ Reaction: ___________________________________

____ Reaction: ___________________________________

Medications, including vitamins, herbs, and supplements: ☐ None ☐ *See attached page
Please include **name, brand, and dose**:

____ ____

____ ____

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: ____

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:____

DENTAL-TMJ

Has the patient had braces? ☐ NO ☐ YES List ages and duration of treatment ____________________________________

____

Is there a concern with the way the teeth come together and bite? ____

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: _______________________