



**Comprehensive • Affordable • Primary & Urgent Care**

## **Pediatric Establish Care Intake Form**

Thank you for scheduling an appointment with Integrative Family Medicine. In an effort to get to know you better, we have included some forms that we would like you to fill out prior to your first visit. The more honest and complete you can be with your answers, the better we will be able to help you. If at all possible, please fill out these forms before coming for your visit.

If for any reason you need to cancel your appointment, we ask that you give us 24 hours notice. We reserve the right to charge you for your appointment if less than 24 hours notice is given.

### **Full payment is due at time of service**

#### **For Medicare and Medicaid Patients Only:**

The services we provide are currently not reimbursable under Medicare or Medicaid. At this time, you may not submit our invoices for reimbursement. However, referrals to specialists, hospitals, and for procedures such as x-rays or MRI would still be covered by Medicare or Medicaid.

For any questions regarding your appointment or these forms, please call us at (828) 575-9600. We look forward to meeting you.

We would like to take this opportunity to acquaint you with our payment procedure. We intentionally do not file insurance at our clinic. Not filing insurance allows us to focus on you as our #1 priority. As a result of not affiliating with insurance companies we can dramatically reduce fees and pass the savings to you, while increasing your quality of care. It is our goal to exceed expectations of our patients and make financial aspects of your healthcare as convenient and simple as possible.

We will provide you with the paperwork necessary to file insurance on your own, though we cannot guarantee reimbursement.

Privacy and confidentiality of personal health information is important to us. We have HIPAA policies in place to ensure your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves our office either electronically, by fax, or paper record without specific authorization by you. A copy of our policy on privacy is posted at the front desk and you may receive a copy if you would like one.

**I have read and understand the payment procedures and privacy policy of Integrative Family Medicine of Asheville and agree to pay my bill in full at the end of my visit. I also authorize release of any necessary medical records by Integrative Family Medicine of Asheville and to send any referrals on my behalf.**

Signed: \_\_\_\_\_ Date \_\_\_\_\_

## PLEASE PRINT AND COMPLETE IN FULL

Date \_\_\_\_\_

Patient's Legal Name:

\_\_\_\_\_  
Last First M Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security Number \_\_\_\_\_

Is Patient enrolled in Medicaid? \_\_\_\_\_

### If Patient is a minor, Parent/Guardians:

#1 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

#2 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address for Parent/Guardian: \_\_\_\_\_

Email Address for Minor, if applicable: \_\_\_\_\_

Preferred Email from above for All Communications (circle one): Parent/Guardian's Minor's

Name & Relationship of Primary Emergency Contact \_\_\_\_\_

Phone number of Emergency Contact \_\_\_\_\_

How did you learn of our office? \_\_\_\_\_

Reason for visit \_\_\_\_\_

How will you pay today? Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_

**Payment is due at time of service.**

## Health History

(Please answer all questions appropriate to the age of your child)

What are your goals for your child's visit today?

---

---

---

---

---

Prioritize your most important concerns for you child's health today?

<u>Concern</u>	<u>Onset</u>	<u>Frequency</u>
<u>Severity</u> Ex: Headache mild/mod/severe	June 2003	4 times/wk
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Has your child seen any other providers for this health concern? If so whom?

---

With whom does you child live? (Including pets)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What school does your child attend? \_\_\_\_\_ What grade? \_\_\_\_\_

Favorite subjects \_\_\_\_\_

What are the most important things to your child?

---

---

What are the major stressors in your child's life?

---

---

What does your child do to relax/relieve stress?

---

---

**What hobbies or interests does your child have?**

---

---

**What are your child's sources of comfort, nurturing, and connection?**

---

---

**How much screen time does your child have in a typical day? (Including TV, Computer, iPad, iPhone, and anything else with a screen) \_\_\_\_\_**

**How does your child do playing with others in group activities? \_\_\_\_\_**

**Do you read to your child? Yes \_\_\_ No \_\_\_ If yes, how often \_\_\_\_\_**

**Have you considered encouraging learning a foreign language, music, or other art form? Yes \_\_\_ No \_\_\_**

**If yes, please describe \_\_\_\_\_**

**Does your child have trouble focusing or following guidance? \_\_\_\_\_**

**Do you have functioning safety plans in the home (smoke detectors, fire escape plan, child-proofed cabinets, toxins out of reach and clearly labeled, safety phone numbers clearly posted?) \_\_\_\_\_**

## **Physical Activity**

**What physical activity does your child participate in, and how often?**

---

---

**How much time does your child spend outdoors each day? \_\_\_\_\_**

**Exercise Frequency:**

- ☐ **Daily exercise or activity for >60 min**
- ☐ **Daily exercise or activity for 30-60 min**
- ☐ **Daily exercise or activity for 15-30 min**
- ☐ **Daily exercise or activity for <15 min**

## Energy and Sleep

How is your child's energy level? \_\_\_\_\_

Describe your child's sleep pattern (bed time, hours of sleep/night. Is it continuous? Are there any difficulties with sleep?)

## Nutrition/Digestion

How many meals does your child generally eat per day? \_\_\_\_\_  
Do they skip meals? \_\_\_\_\_

How many servings of fruit per day and what kind? (Sv: 1 small fruit, ½ Cup canned/chopped fruit, ½ Cup dried fruit)

How many servings of vegetables per day and what kind? (Sv: ½ Cup raw/cooked, 1 Cup leafy veg.)

Is your child currently on a special diet? (Vegetarian, macrobiotic, vegan, raw, other)

What are your child's favorite foods? \_\_\_\_\_

Food allergies, sensitivities or foods that your child avoids?

Does your child consume dairy? If so, how much and what kind (milk, cheese, yogurt?)

**What amount and kind of carbohydrates does your child eat?** (grains, flour, bread, pasta, starchy vegetables)

---

---

**What are your child's sources of protein?** \_\_\_\_\_

**What type of oil, butter, or spreads is typically used on your child's food?**

---

---

**What and how much does your child drink on a typical day?** (water, tea, caffeinated drinks, bottled drinks, soda, etc.)

---

---

**How would you describe your child's relationship with food?**

---

---

**How often and where does your child eat out?**

---

---

**Does your child eat organic food?** \_\_\_\_\_

**What type and how much does your child consume of sweetened products (natural foods, juices, drinks, sodas, etc)**

---

---

**Has your child's weight been stable?** Yes \_\_\_\_ No \_\_\_\_

**Who prepares the meals at home?**

---

**Do you feel knowledgeable about the nutritional needs of your family?** Yes \_\_\_\_ No \_\_\_\_

**Is there a water purifier used at home?** \_\_\_\_\_

**Does your child feel frequent (circle) :** bloating      reflux      constipation      loose stools  
pain after eating

**How frequently does your child have a bowel movement?**

---

Does your child have difficulty digesting (circle): soy wheat dairy nightshades

How often does your child eat tuna, yellowfin, or other large fish? \_\_\_\_\_

Please describe your child's typical diet:

**Breakfast**

---

---

**Lunch**

---

---

**Dinner**

---

---

**Snacks**

---

---

**Beverages**

---

---



## Family History

**Who in your immediate family has any of the following?**

**Place appropriate letter in blank and circle type: (F=Father, M=Mother, S=Sister, B=Brother, Son=son, D=daughter)**

Ex: F High Blood Pressure

\_\_\_\_\_ Alcoholism or Substance Abuse  
tension, cluster, aneurysm)

           Anxiety

## Disease, Heart Failure

\_\_\_\_\_ Anemia (Sickle Cell or Other)

(Other Type \_\_\_\_\_)

## Asthma

\_\_\_\_\_ Arthritis (Type\_\_\_\_\_)

## Syndrome

## Blood clots

\_\_\_\_\_ Cancer (Type \_\_\_\_\_)

(Hepatitis, etc.)

## Chronic Pain

(Asthma, COPD, emphysema)

Depression

psychosis/ nervous breakdown

Diabetes

Digestive (Ulcerative Colitis, Crohns, etc.)

Disability (From )

suicide

## Easy Bleeding

(Goiter, high or low thyroid)

## Glaucoma

## High Blood Pressure

## Hay Fever, Allergy, Eczema

\_\_\_\_\_ Headaches (Migraine,

## Heart Attack, Heart

## Heart Failure

           Heart arrhythmia

\_\_\_\_\_ High Cholesterol

## Irritable Bowel

\_\_\_\_\_ Kidney Disease

## Liver Disease

           Lung Disease

\_\_\_\_\_Mental Trouble/

Seizure, Epilepsy

Stroke

\_\_\_\_\_ Suicide or attempted

## Thyroid Disease

Tuberculosis (TB)

## Ulcers

Other

## Past Medical History

**Please list any operations/ surgical procedures/ hospitalizations, blood transfusions/major injuries or illnesses (with dates):**

- 1) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 2) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 3) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 4) Year: \_\_\_\_\_ Condition \_\_\_\_\_

**Please list any illnesses that have required your child to miss school, change lifestyle, or that required medication:**

- 1) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 2) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 3) Year: \_\_\_\_\_ Condition \_\_\_\_\_
- 4) Year: \_\_\_\_\_ Condition \_\_\_\_\_

**Immunizations/vaccinations:** Yes \_\_\_ No \_\_\_ Partial \_\_\_ Delayed Schedule \_\_\_  
Up to date? Yes \_\_\_ No \_\_\_

**Does your child have any Medication, Food, or Environmental allergies?**

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

**If answer was yes above, please list medication or substance and the reaction (what happened when your child took it?):**

Medication/Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

## **Pregnancy with child?**

**Birth:** Term \_\_\_\_\_ Premature \_\_\_\_\_ Weight \_\_\_\_\_ Vaginal Delivery \_\_\_\_\_

**Caesarian Section** \_\_\_\_\_

**Were there any problems with pregnancy/labor/delivery** Yes \_\_\_ No \_\_\_

**If yes, please describe**

\_\_\_\_\_

**Breast-fed?** Yes \_\_\_ No \_\_\_ **If yes, what age was your child when they were weaned from breast feeding?** \_\_\_\_\_

**What age did your child begin:**

**Sitting** \_\_\_\_\_ **Crawling** \_\_\_\_\_ **Walking** \_\_\_\_\_ **Talking** \_\_\_\_\_

**Has your child ever been under the care of a mental health professional** \_\_\_ Yes \_\_\_ No

**If yes, please list condition, date, mental health provider and location of the hospital or treatment facility.**

<u>Condition</u>	<u>Date</u>	<u>Provider</u>
<u>Hospital/Treatment facility</u>		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

## **Parental Wellbeing**

**What are your methods of coping with stress as a parent?**

\_\_\_\_\_

**What assistance do you have in caring for your child (family support, friends, hired help, parent groups, etc?)**

\_\_\_\_\_

\_\_\_\_\_

Are both parents involved in child care? \_\_\_\_\_

Do you feel that the home is a safe and nurturing environment for your child? If not, what do you feel are the disrupting factors? \_\_\_\_\_  
\_\_\_\_\_

Is there any substance use in the home (tobacco, alcohol, other?) Yes \_\_\_ No \_\_\_ If yes, what substance \_\_\_\_\_

Are there guns or weapons in the home? If so, are they safely locked? \_\_\_\_\_

Do you feel that as a parent you are caring for yourself and your relationship with your partner? \_\_\_\_\_  
\_\_\_\_\_

**PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication your child takes or uses.**

<b>Name of Medication and dose.</b>	<b>How often does your child use this medication?</b>	<b>When did your child begin taking this medication.</b>	<b>Condition treated with this medication.</b>	<b>Date and reason medication was stopped.</b>

<b>Name of product and list of ingredients.</b>	<b>Dosage and Frequency taken</b>	<b>Date supplement was started and the condition the supplement was treating</b>	<b>Date supplement was stopped.</b>	<b>Reason supplement was stopped.</b>

# Symptom checklist

(Please check all symptoms, if any, that your child has experienced during the last 3 months)

## General

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Heat/Cold Intolerance
- ☐ Insomnia
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Motion/Car Sickness
- ☐ Other: \_\_\_\_\_

## Head, Eyes, Ears, Nose

- ☐ Headache
- ☐ Migraine
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Changes in Hearing
- ☐ Itchy/Watery Eyes
- ☐ Dry or Red Eyes
- ☐ Eye Pain
- ☐ Changes in vision
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Sinus Infection/pain
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Other: \_\_\_\_\_

## Cardiovascular

- ☐ Congenital Heart Defects
- ☐ Heart Murmur
- ☐ Easy bruising
- ☐ Anemia
- ☐ Cold hand/feet
- ☐ Other: \_\_\_\_\_

## Respiratory

- ☐ Difficulty breathing
- ☐ Exercise intolerance
- ☐ Cough
- ☐ Hoarseness of voice
- ☐ Snoring
- ☐ Asthma or wheezing
- ☐ Other: \_\_\_\_\_

## Gastrointestinal

- ☐ Bloating and Flatulence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Nausea
- ☐ Blood and/or mucus in stool
- ☐ Pain during bowel movements
- ☐ Anal Fissures
- ☐ Other: \_\_\_\_\_

## Eating and Appetite

- ☐ Difficulty gaining weight
- ☐ Difficulty losing weight
- ☐ Frequent dieting
- ☐ Poor appetite
- ☐ Always hungry
- ☐ Emotional eating
- ☐ Cravings
- ☐ Binge eating
- ☐ Anorexia or bulimia
- ☐ Other: \_\_\_\_\_

## Psychology and Nervous System

- ☐ Anxiety or panic attacks
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Irritability
- ☐ Nightmares
- ☐ Unusual Fears
- ☐ Difficulty with speech
- ☐ Seizures
- ☐ Trembling or tremor
- ☐ Hyperactivity
- ☐ Fainting or feeling lightheaded
- ☐ Other: \_\_\_\_\_

## Musculoskeletal

- ☐ Joint pain, redness, or stiffness
- ☐ Neck or back pain
- ☐ Foot cramps
- ☐ Wrist or hand pain
- ☐ Joint deformity

- ☐ Muscle pain or cramps
- ☐ Muscle weakness
- ☐ Restless legs
- ☐ Tendonitis
- ☐ TMJ/Jaw pain
- ☐ Other: \_\_\_\_\_

## Urinary

- ☐ Acute or Chronic UTI's
- ☐ Incontinence or dribbling
- ☐ Pain or burning with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Bedwetting
- ☐ Other: \_\_\_\_\_

## Immune

- ☐ Enlarged lymph nodes
- ☐ Painful or tender lymph nodes
- ☐ Frequent infections
- ☐ Frequent colds or flu
- ☐ Slow wound healing
- ☐ Other: \_\_\_\_\_

## Skin and Nails

- ☐ Acne
- ☐ Athletes foot
- ☐ Jock Itch
- ☐ Dandruff
- ☐ Dark circles under eyes
- ☐ Profuse sweating
- ☐ Rashes or hives
- ☐ Dry or itchy skin
- ☐ Bumps on the back of arms
- ☐ Suspicious moles
- ☐ Changes in pigment
- ☐ Hair loss
- ☐ Brittle or breaking nails
- ☐ White spots or ridges on nails
- ☐ Jaundice
- ☐ Other: \_\_\_\_\_

### **Other Providers on Your Child's Health/Wellness Team**

**Please list the name and title of all other providers currently supporting you (ie. acupuncturist, physical therapist, specialists, etc.):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_