Integrative Family Medicine of Asheville, PLLC

Comprehensive • Affordable • Primary & Urgent Care

Pediatric/Ages 17 & Under 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 can 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 we are happy to provide you with a copy at your request.

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 visits. I also authorize release of any necessary medical records by Integrative Family Medicine of Asheville and delivery of referrals on my behalf.

Signed:_____Date _____

PLEASE PRINT AND COMPLETE IN FULL

Date_____

Patient's Legal Name:

_____ Nickname_____
Last First M

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_____

Preferred pharmacy name & location_____

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?

	Concern	Onset	Frequency	Severity
	Ex: Headache	June 2003	4 times/wk	mild/mod/severe
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? (Svg: 1small fruit, ½ Cup canned/chopped fruit, ½ Cup dried fruit)

_____

_____

How many servings of vegetables per day and what kind? (Svg: 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

_____ Anxiety

_____ Anemia (Sickle Cell or Other)
(Other Type_____)

_____ Asthma

_____ Arthritis (Type_____)

_____ Blood clots

_____ Cancer (Type _____)

_____ Chronic Pain

_____ Depression

_____ Diabetes

_____ Digestive (Ulcerative Colitis, Crohns, etc.)

_____Disability (From_____)

_____ Easy Bleeding

_____ Glaucoma

_____ High Blood Pressure

_____ Hay Fever, Allergy, Eczema

_____ Headaches (Migraine, tension, cluster, aneurysm)

_____ Heart Attack, Heart Disease, Heart Failure

_____ Heart Failure

_____ Heart arrhythmia

_____ High Cholesterol

_____Irritable Bowel Syndrome

_____ Kidney Disease

_____ Liver Disease (Hepatitis, etc.)

_____ Lung Disease (Asthma, COPD, emphysema)

_____ Mental Trouble/ psychosis/ nervous breakdown

_____ Seizure, Epilepsy

_____ Stroke

_____ Suicide or attempted suicide

_____ Thyroid Disease (Goiter, high or low thyroid)

_____ 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 and Postpartum 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?_____

Child Development and Mental Health

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.

Condition; Hospital/Treatment Facility	Date	Provider
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Parental Well-being

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? Yes___ No___

If so, are they safely locked?_____

Do you feel that as a parent you are caring for yourself and your relationship with your partner (if applicable)?

_____

_____

_____

PRESCRIPTION MEDICATIONS

***Please list on the table below ALL prescription medication your child takes or uses**:*

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

NON-PRESCRIPTION MEDICATIONS AND SUPPLEMENTS CURRENTLY OR RECENTLY TAKEN

(Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products)

Name of product and list of ingredients.	**Dosage and Frequency taken**	**Date supplement was started and the condition the supplement was treating**	**Date supplement was stopped.**	**Reason supplement was stopped.**

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. _____