

Sara Ohgushi, N.D.

2207 NE Broadway, Suite 200, Portland OR 97232
Phone 503-703-7825; FAX 503-232-3436

Pediatric Intake Form

Confidential Patient Information

Child's name _____ Birthdate _____ Age _____ Today's Date _____

Social Security # _____ Parents/Guardian _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____

Pager/Cell _____ Email _____

Emergency Contact Person _____ Phone _____

Relationship _____ Address _____

Insurance Co. _____ Address _____

Policy# _____ Group# _____ Policyholder _____ Birthdate _____

(Please allow us to copy your insurance card.)

Assignment and Release: I hereby authorize my insurance benefits be paid directly to this physician, and I understand that I am financially responsible for non-covered services. I also authorize this physician to release any information required to process this claim.

Signature

Date

What are your top three health concerns for your child?

1) _____

2) _____

3) _____

List any medications (prescription or over the counter) and/or supplements your child is taking:

List any known allergies to food, drugs or chemicals _____

Is your child currently under a physician's care? _____ If yes, physician's name _____

Last physical exam _____ Last blood work _____ Last dental exam _____

Brief summary of the pregnancy carrying this child: _____

Brief summary of this child's birth: _____

(Continued on back...)

Medical History and Family History

Please write child's initials or identify a family member (siblings, parents, grandparents, aunts/uncles) next to the medical conditions your child or they have suffered:

- | | | |
|--------------------------------|------------------------------|-------------------------------|
| ____ ADD/ADHD | ____ Diarrhea | ____ Kidney disease |
| ____ Allergies/hay fever/hives | ____ Ear infections | ____ Learning disabilities |
| ____ Anemia | ____ Eating disorders | ____ Menstrual disorders |
| ____ Asthma | ____ Eczema | ____ Osteoporosis |
| ____ Athletes foot | ____ Glasses/Contacts | ____ Pneumonia/lung disease |
| ____ Birth defect | ____ Headaches/migraines | ____ Rheumatic/scarlett fever |
| ____ Bleeding disorders | ____ Hearing loss | ____ Seizures |
| ____ Breast disorders | ____ Heart disease | ____ Thyroid disease |
| ____ Cancer | ____ Heartburn/reflux | ____ Tuberculosis |
| ____ Colic | ____ Hepatitis/liver disease | ____ Ulcers |
| ____ Colds, frequent | ____ High blood pressure | ____ Urinary tract infections |
| ____ Constipation | ____ High cholesterol | ____ Vaginal infections |
| ____ Depression/anxiety | ____ Hypoglycemia | ____ Vertigo/dizziness |
| ____ Diabetes | ____ Insomnia | ____ Other _____ |

Major illnesses/accidents/hospitalizations/surgeries: _____

Immunizations received and any adverse reactions: _____

Health Habits

Sleep: Average # of hrs _____ Quality _____

Is your child breastfeeding? _____ If not, how long were they breastfed? _____

Age at which solids were introduced: _____

Your child's typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Does anyone in the home smoke? _____

List any weapons in your home: _____

Does your child ride in a carseat every car ride? _____

Does your child wear a helmet when riding a bicycle? _____

Lastly, how did you hear of my practice? _____