Ridgeview SPECIALTY CLINIC

Pediatric Integrative Medicine

New Patient Intake Questionnaire

*Please fax completed form to (**952) 361-2467** or mail:*
Attn: Intake Coordinator, Pediatric Integrative Medicine, 111 Hundertmark Road, Suite 470, Chaska, MN 55318

Child's Name:	**Form Completed By:**	
Parent's Name:	**Date Form Completed:**	
Child's Date of Birth:	**Child's Age:**	**Child's Sex: M F**
Primary Insurance:	**Group #:**	**ID #:**
Referred By:		

Referral Information/Specialists Working With Your Child

Primary Physician:	Physician:
Address:	Address:
Phone: Fax:	Phone: Fax:

Psychologist/Therapist:	Other Specialist (Including OT, PT, Speech):
Address:	Address:
Phone: Fax:	Phone: Fax:

Please summarize in 3 to 5 sentences your main concerns at this time:

What are your goals for work at our clinic?

1. _____

2. _____

3. _____

Do you have a preferred appointment type*? ☐ **Medical Only** ☐ **Psychology Only** ☐ **Both** ☐ **Either/Not Sure**

* Our clinic will consider your preference during the scheduling process however further recommendations may be advised.

Complementary/Alternative Medicine (CAM) Information

Have you used any alternative or complementary therapies for your child?

Name of therapy	What was it used for?	How often was it used?	Did it work?	Are you still using it?

What CAM therapies are you possibly interested in? *(please circle)*

Acupuncture Aromatherapy Massage Healing Touch Biofeedback

Guided Imagery Hypnosis Craniosacral Therapy Nutritional Counseling Homeopathy

MEDICAL OVERVIEW

Has your child been diagnosed with a behavioral, emotional, psychological or chronic medical problem? List:

Diagnosis	Age at diagnosis	Clinic where diagnosed

If none diagnosed, do you wonder about any diagnosis for your child?

_____

Please check any symptoms/concerns you have about your child at this time:

☐ Pain management ☐ Joint aches ☐ Headaches ☐ Back/Neck pain ☐ Seizures
☐ Stomach aches ☐ Constipation ☐ Toileting ☐ Behavior ☐ Depressed mood
☐ Anxiety ☐ Fatigue ☐ Nutrition ☐ Sleep ☐ Exercise
☐ Motor skills ☐ Social skills ☐ Communication/Speech ☐ Other _____

Does your child take any medications? ☐ No ☐ Yes (If yes, please complete)

Name of medication	What is it used for?	Dosage and how often?	How long?

Is your child taking any herbals, homeopathic remedies, vitamins or neutraceuticals? ☐ No ☐ Yes

Name	What is it used for?	Dosage and how often?	How long?

Does your child have allergies? ☐ No ☐ Yes

Name of food/medication/latex	Age at reaction	Type of Reaction

Has your child ever been hospitalized? ☐ No ☐ Yes, date: ____ Describe_____
Has your child ever had surgery? ☐ No ☐ Yes, date: _____ Describe_____

Please describe events surrounding the onset of your child's medical problems and the impact it has had on your child and family:

_____
_____

Has your child or anyone in the child's family (mother, father, sibling) ever received psychological treatment?

☐ No ☐ Yes

Child or family member	Dates and reason for treatment	Provider/Clinic

FAMILY INFORMATION

	Parent 1	**Parent 2**
Name		
Address City, State, ZIP		
Home Phone		
Work Phone		
Cell Phone		
Education Level/Occupation		

Family Status:

☐ Married (date:) ☐ Separated (date:) ☐ Divorced (date:) ☐ Never Married

If separated, child's primary legal residence is with whom?_____

Does your child have stepparents? ☐ No ☐ Yes, please complete:

	Step Parent 1	**Step Parent 2**
Name		
Address City, State, ZIP		
Home Phone		
Work Phone		
Cell Phone		
Education Level/Occupation		

Was your child adopted? ☐ No ☐ Yes How old was your child at the time of adoption? ____

Additional caregivers involved? ☐ No ☐ Foster Parent ☐ Legal Guardian

Child's Siblings

Name	Age	Grade	Relation to child? (full, half, step)	Where living?	Any concerns?

Please describe family relationships:

_____

_____

_____

Has your child and/or family experienced any *recent* *stressful events (last 6 months)?*

(Examples: arguments with family/friend, peer problems, death, divorce, illness, financial problems)

☐ No ☐ Yes, please explain:

_____

_____

_____

Has your child experienced any stressful events in his or her *lifetime*?

☐ No ☐ Yes, please explain:

_____

_____

_____

PSYCHOSOCIAL HISTORY

Please list your child's unique **strengths:**

_____
_____

Describe your child's **personality** including both positive and negative descriptors
(e.g., happy, stubborn, rigid, easygoing, perfectionist):

_____
_____

Describe your child's **coping style** and how effective it is:

_____
_____

BIRTH/DEVELOPMENTAL HISTORY

Normal vaginal delivery ___ Elective C-section ____ Emergency C-section ____
Child born at how many weeks gestation? ____ Birth weight? ___ lbs. ___ oz.

Please list any complications:
During pregnancy:

_____

During labor and delivery:

_____

Please list any medical, physical or other problems noted for this child ***within his/her first year of life:***

_____
_____

Please list any problems or concerns noted during your child's ***first 5 years of life*** in terms of meeting expected developmental milestones (sitting, crawling, walking, talking, riding a bike, school readiness, social, motor or behavioral skill development):

_____
_____
_____

Has your child shown any loss of previous abilities (e.g., he was speaking two-word sentences and then stopped talking):

_____
_____
_____

Date of your child's last hearing and vision screen: _____

CURRENT BEHAVIOR

Does your child experience any of the following difficulties with **sleep?**

☐ Difficulty falling asleep ☐ Waking in the night ☐ Early morning waking
☐ Falls asleep during day ☐ Nightmares ☐ Night terrors ☐ Sleeps too much

Does your child have any of the following concerns with **nutrition/exercise?**

☐ Poor food choices ☐ Excessive physical activity
☐ Overeats ☐ Limited physical activity
☐ Avoids foods due to texture ☐ Lack of interest in physical activity
☐ Skips meals

SENSORY EVALUATION

Please describe your child's sensitivity regarding the following senses:

Touch: ☐ No sensitivity ☐ Yes, please explain: (e.g., behavior regarding being touched, clothing preferences)

_____

_____

Movement: ☐ No sensitivity ☐ Yes, please explain: (types of movement your child likes/dislikes, behavior being moved)

_____

_____

Sound: ☐ No sensitivity ☐ Yes, please explain: (loud sounds, filtering out sound)

_____

_____

Visual: ☐ No sensitivity ☐ Yes, please explain: (sensitivity to light, sustain visual attention)

_____

_____

SCHOOL INFORMATION

School Name:	Grade:
Address:	Teacher:
Phone:	Fax:

Do you have any specific concerns about your **child's school progress** (such as academics, social, teacher or peer relationships)

☐ No ☐ Yes, explain

_____

_____

Has your child missed school in the past year?

☐ 1–10 days ☐ 11–25 days ☐ 26–50 days ☐ 50+ days

Has your child had a school evaluation due to special learning needs? ☐ No ☐ Yes

Does your child have an Individualized Education Plan (IEP)? ☐ No ☐ Yes

Does your child have a 504 Plan? ☐ No ☐ Yes

FAMILY MEDICAL HISTORY

Please check all medical conditions that have occurred with the child's biological relatives:

Child's:	**Mother**	**Father**	**Sibling** specify sister (S) or brother (B)	**Aunt**	**Uncle**	**Grandparent** Specify grandmother (GM) or grandfather (GF)	**Cousin**	**Other**
				Indicate which side of the family, mother (M) or father (P)				
Anxiety								
Alcohol dependency								
Attention deficit disorder								
Autism								
Bipolar (Manic/depressive)								
Chemical dependency								
Chronic illness (please specify: i.e., asthma, arthritis, lupus, cancer)								
Congenital disorder								
Crohns disease/Colitis								
Depression								
Diabetes (specify type I or type II)								
Irritable bowel syndrome								
Learning disability								
Mental retardation								
Obsessive-compulsive disorder								
Schizophrenia								
Sleep disorders								
Speech/Language disorders								
Suicide attempt/psychiatric hospitalization								
Thyroid disease								
Other								

Thank you for your time and effort in completing this form.
It greatly helps in our work with your child and family.

Spiritual Orientation *(optional)*

Please list your family's spiritual orientation or religion: _____

How active are these beliefs in your life?
☐ **Very active** ☐ **Somewhat active** ☐ **Not very active**

Share some of your thoughts on your spiritual practice/religion (i.e., what are your beliefs, how have these beliefs impacted your child's health and well-being).
_____
_____

Pain Assessment *(Please complete only if your child has pain symptoms)*

Was this a result from an injury? ☐ No ☐ Yes
When did this problem start?_____

Location of pain: _____

Grade severity of the pain by circling the number that corresponds with the current level:
(0=No pain 10=Worst pain possible) 0 1 2 3 4 5 6 7 8 9 10

Please rate your child's abilities to do the following activities (despite his/her pain)

Sleep:	Good	Fair	Poor	Can't do it	
Chores:	Good	Fair	Poor	Can't do it	
Sports/recreation:	Good	Fair	Poor	Can't do it	Please list activity:_____
School:	Good	Fair	Poor	Can't do it	

Pain is currently: _____Constant _____Intermittent _____Brief
Recently, the pain has been: _____Getting better _____Staying same _____Getting worse

How would you describe your child's pain?
_____Sharp _____Dull _____Achy _____Burning

When is the pain the worse?
_____Morning _____Afternoon _____Evening _____Night _____No pattern

What makes the pain worse? _____

Do they experience any associated symptoms?
_____Numbness _____Weakness arms/legs _____Loss of bladder/bowel control

What have you tried to help with the pain? _____
What has been most helpful to relieve pain? _____
What are you doing currently? _____