Osteopathic Integrative Medicine, INC.

9600 W. Jewell Ave. STE 3

Lakewood, CO 80232

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Pediatric Patient Questionnaire

(Please Print)

Child's Name_____ Today's Date_____

Parent(s) Name(s): _____

What do you want to be called? Your child? _____

Date of Injury/ Onset of symptoms _____

Date of Birth _____ Age ____ Height _____ Weight _____

Chief Complaint _____

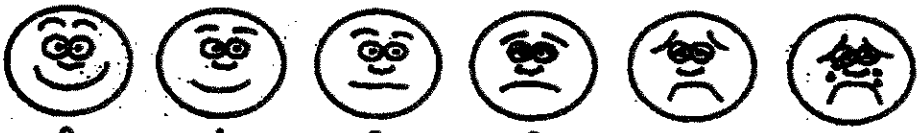
_____

_____

_____

_____

If your child is able, circle the face that best describes his/her symptoms:



0 No Hurt | 1 Hurts Little Bit | 2 Hurts Little More | 3 Hurts Even More | 4 Hurts Whole Lot | 5 Hurts Worst

BIRTH HISTORY:

Delivery (circle one): Vaginal / C-Section Reason for C-Section: _____

Time Pushing (active labor): _____

Delivery: Hours of Labor _____

Did mother have (circle): Medications Caffeine Tobacco Alcohol/Street Drugs Stresses

Medicines Used During Labor/Delivery: _____

Epidural: Yes / No Pitocin augmentation: Yes / No Forceps or vacuum: Yes / No

Presentation: Vertex _____ Breech _____ Transverse _____

APGAR_____ First Cry: Strong / Weak/ No Recall Wt_____lbs___oz. Length _____

Complications Mother: _____

Complications Baby: _____

Immediate to breast? Yes / No Breast or Bottle Fed Suck Strong? Yes / No

Spit-up? Yes / No Vomit? Yes / No

Formula name: _____changed? Yes / No. If yes, to what? _____

Colic? Yes / No Sleeps well? Yes / No # of hours _____

Solid Foods? Yes / No What Age? _____ Feeds Self? Yes / No

Milestones Met? Yes / No If no, which? _____

Immunizations up to date? Yes No Reactions: _____

Food intolerances/allergies: _____

Drug Allergies: _____

List ALL medications/supplements/vitamins: _____

_____

_____

_____

_____

_____

PMHX:

Diagnostic Testing? (i.e. blood work, x-rays, allergy testing, etc.)

_____

_____

Traumas/Accidents/Injuries: _____

_____

Illness/Hospitalization: _____

_____

_____

FAMILY HISTORY:

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	LIVING?	AGE	ILLNESSES and/or CAUSE OF DEATH
MOTHER			
FATHER			
SIBLING 1			
SIBLING 2			
SIBLING 3			

Parents Marital Status: Married / Single / Divorced / Separated

Child lives with: _____

REVIEW OF SYSTEMS

(Please check next to the areas that apply to your child.)

Constitutional		
Weight gain- 6 months	Weight Loss- 6 months	Night Sweats
Chills	Fever	
Skin		
Easy Bleeding	Any Rashes	Easy Bruising
Eyes, Ear, Nose, And Throat (recent)		
Changes in vision	Changes in Smell	Any Dizziness
Changes in Hearing	Changes in Taste	Any Ringing
Respiratory		
Shortness of Breath	Sputum	Wheezing
Cough	History of Tuberculosis	
Cardiovascular		
Chest Pain	Shortness of Breath	Feet Edema
Palpitations	Heart Murmur	
Gastrointestinal		
Chewing	Swallowing	Indigestion
Nausea	Diarrhea	Abdominal Pain
Vomiting	Bloating	Bloody or Dark Stools
Reproductive		
Age of first period	Excessive Menstrual Symptoms	Irregular periods
Genito-Urinary		
Blood in Urine	Unable to Control Bladder	Rushing to Urinate
Urinary Tract Infections	Need to Urinate frequently	
Musculoskeletal		
Cramps/Aches	Joint Pain	Joint Swelling
Attacks of Weakness	Morning Stiffness	
Central Nervous System		
Poor Appetite	Numbness/Tingling Feet	Crying Spells
Problem Sleeping	Numbness/Tingling Hand	Convulsions
Headaches	Fainting	

Parent/Guardian Signature _____ Date _____

The preceding patient information packet has been reviewed and discussed with the patient.

Physician Signature _____ Date _____

WELCOME TO THE OFFICE OF
Osteopathic Integrative Medicine

Welcome to our office and thank you for choosing us as your health care provider. We are committed to your treatment being successful and strive to help you achieve optimal health. We feel it is helpful to understand our office and financial policies prior to starting treatment. The following information makes it possible to offer you the highest quality of care.

INSURANCE BILLING:

We will bill your insurance company when appropriate for the services performed at our office. However, you have ultimate responsibility for paymant of your account. Please furnish our office with all of the necessary information required for billing your insurance.

PATIENT PAYMENT:

Co-payment or payment for services not covered by insurance is required to be paid at the time of service. $25.00 charge for all returned checks. There will be a finance charge of 1.5% charged to accounts more than 30 days old. 90 days without payment made to your account, will result is a 30% collection agency fee based upon the full balance due and your account will be sent to our collection agency. At this time we do not accept auto insurance. We do treat auto-accident patients through their personal health insurance or through self-pay. It is the responsibility of the patient to submit receipts for any treatment for reimbursement for their auto case.

Many insurane plans are moving into high deductible plans, we will check your insurance plan before your first visit and determine your approximate benefit plan. Those with high deductable plans will be charged $300.00 at the time of your first visit, and $150.00 for each follow up visit until the deductable is met. This is an approximate charge for your basic visits, all insurance policies differ and there is no way of predicting the exact amount insurance will ultimately charge you. If we charged too much, you will be refunded. Also, there are proceedures offered at this office that an additional charge.

APPOINTMENTS:

As a courtesy, you will be receiving a reminder phone call one day in advance of your appointment. Please notify our staff if you do not wish to be contacted or if you do not wish to receive a voice message regarding your appointment. In order to keep our schedule running smoothly, we ask that you arrive for you appointment on time. If you arrive more than 10 minutes late to an appointment, you may be re-scheduled.

We require a 24-hour cancellation notice. Cancelled follow-up appointments, with less than 24 hours notice as well as no-shows, will be subject to a fee of $85.00 fee. Three late re-schedules, no-shows, cancellations or combination thereof may result in a discharge of care.

MISCELLANEOUS:

Those with children are encouraged to consider outside babysitting arrangements, as our staff will be unable to supervise them for you. We wish to promote a quiet and relaxing atmosphere for you and all our patients.

Please understand that prescription refills, authorization for services outside of our office, referrals and/or special doctor requests may require a minimum of 48 hours to process. Please give our office enough notice to process requests in a timely manner.

If you have questions or concerns regarding these or other policies, please ask a member of our staff.
I have read, understand and agree to the provisions of this office/financial policy.

Signed_____ **Date**_____

NOTICE OF PRIVACY PRATICES (HIPPA)
OSTEOPTHIC INTAGRATIVE MEDICINE

The HIPPA privacy act went into effect on April 14, 2003.

The following is a basic summary of some of your rights regarding how we may use and disclose medical information about you:

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to nurses, technicians, medical students, other physicians, and/or hospital personnel who are involved in your care.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party (i.e. auto insurance).

At this time we do not accept auto insurance. We do treat auto-accident patients through their personal health insurance or through self-pay. It is the responsibility of the patient to submit receipts for any treatment for reimbursement for their auto case.

For Health Care Operations: Members of the staff may use information in your health record to assess the care and outcomes in your case and others like it. For example, we may combine medical information about many patients to evaluate the need for new services or treatment.

There is more information about your HIPPA rights at the office. Please ask our staff to provide a copy to you upon arrival.

I acknowledge that I was informed of the privacy practice of Osteopathic Integrative Medicine:

Date: _____

Patient's Name: _____

Patient's Signature: _____

Staff Signature: _____