BioFXN
Personalized Innovative Healthcare

Dr. Anna Martin, ND
Functional Medicine Doctor

Powered by Rebound SportsMed

Pediatric Intake Form

Date: _____

Child's last name: _____ Child's first name: _____ M. I. _____

Nickname(s): _____ Birth date: _____ Sex: _____

Parent/Guardian: _____ Parent/Guardian: _____

Sibling (s):_____

A note to our patients: Please complete this form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, except when you have provided us with written authorization to do so or as required by law. Thank you.

Besides mother and father, does anyone else take care of the child? No Yes Who? _____

Has the child received healthcare elsewhere? No Yes Where? _____

Has the child been immunized? No Yes Which ones? _____

When? _____

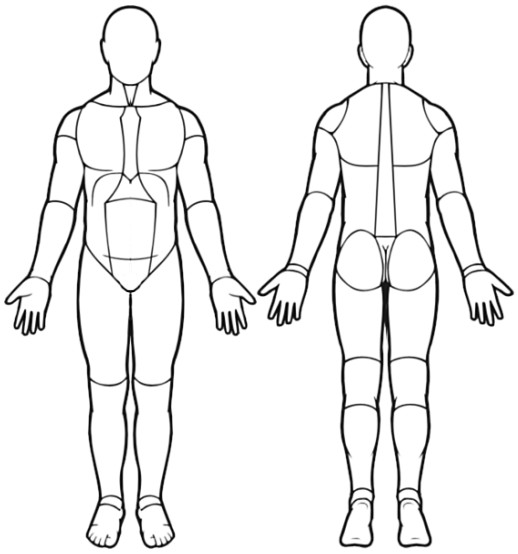
How would you rate this child's health in general? (Circle) Excellent Good Fair Poor

Do you have concerns about the child's behavior or development? No Yes What?_____

Do you have any concerns about the child's nutrition or growth? No Yes What?_____

Date of last physical/annual exam: _____ Date of last blood tests: _____

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		

What goals do you have for your visit at the clinic today? _____

_____

Do you have any questions about our clinic or care? _____

Please list any prescription medications, over the counter drugs, supplements, vitamins, herbs, homeopathic remedies, etc that the child is currently taking with dosages: _____ _____

_____

Please list any allergies to medication or life threatening allergies and reaction_____

_____

Family health habits:

How often does your child use a seatbelt (car seat)? Never Rarely Sometimes Often Always

Does your child ride a bicycle? How often does she/he use a helmet?

Never Rarely Sometimes Often Always

Does your home have smoke detectors? Yes No Does your home have a fire extinguisher? Yes No

Do you feel that you live in a safe place? Yes No

In the past year, have you felt threatened in your home? Yes No

What kinds of guns are in your house? Handgun Shotgun Rifle Other None

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No If yes, who? _____

Do you currently smoke cigarettes? Yes No If yes, how many? _____

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Past history: Please circle those that apply to child

- Frequent Ear Infections
- Allergies, Hay Fever
- Eczema, Psoriasis
- Anemia
- Heart Murmur
- Vision Problems
- Kidney or Bladder Infections
- Seizures
- Broken Bones
- Hearing Problems
- Bed Wetting
- Injury or Abuse
- Asthma
- Pneumonia, Bronchitis, Persistent Cough

Family Medical History:

Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pres			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Patient Information Form

Last Name:_____ First Name:_____ M.I. ____ Today's Date:_____

Other names or nicknames your records may be kept under:_____

Address:_____ Apartment #:_____

City: _____ State: _____ Zip code:_____ Country: _____ Sex: _____

Occupation: _____ Employer/School: _____

Phone: (___)_____ Work Phone: (___)_____ ext:_____ Date of Birth: _____

Social Security #: _____ Will you be applying for our reduced rate if not insured? Yes No

Parent/Gaurdian Name (minors only) _____ Parent/Guardian Name (minors only) _____

Emergency Contact: _____ Contact's Phone #: (___)_____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: _____ (or) Special needs?: _____

How did you hear about us? _____

Personal Injury Protection (PIP) Claims

If you have an open personal injury claim and are wanting to use this as a form of payment, you must first receive permission from our office and fill out the personal injury intake forms.

Injury type and date. Please also include any additional information about the claim, other providers involved, and other treatments performed on the

claim:_____

_____

_____

_____

_____

_____

_____

_____

_____

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic. I understand that if I am providing PIP information, I am financially responsible for all charges whether or not they are paid by my PIP claim. I hereby authorize BioFXN, PLLC and/or Rebound SportsMed to release all information necessary to secure the payment of your claim, and I authorize the use of this signature on all my submissions.

X_____ _____ X_____ _____

Signature of patient* date Signature of guardian date

Relationship to patient: _____

* Guardian's signature required for minors.