34474-08

Children's Physician Group - Rheumatology
Children's Specialty Services

NEW PATIENT INTAKE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Your child has been referred to Children's Physician Group. **Please fill out this form and bring it to your child's appointment.** This information is confidential unless you sign a release form. Please print clearly and carefully.

Background Information			
Child's Name:	**Birth date:**	**Age:**	☐ **Male** ☐ **Female**
Mom's Name:	**Dad's Name:**		
Guardian's Name:			
Address:			
City:	**State:**	**Zip:**	
Home Phone:	**Mom's Work:**	**Mom's Cell:**	
Ok to leave a voicemail? ☐ **Yes** ☐ **No**	**Dad's Work:**	**Dad's Cell:**	
	Mom's Email:	**Dad's Email:**	

Reason for Visit	
Referring Physician:	**Pediatrician:**
Why are you seeing us today?	
What problem is your child having now?	
When did the problem start?	
Have you been given a diagnosis?	
Has your child had any lab or imaging tests (list type if known)?	
Has your child had any treatments?	
Who else have you seen for this problem?	

Questions for our Team
Question:
Question:
Question:
Question:

Because of your child's health problem(s), does he/she have trouble:			
Getting dressed?	☐ Usually	☐ Sometimes	☐ Never
Walking?	☐ Usually	☐ Sometimes	☐ Never
Going up stairs?	☐ Usually	☐ Sometimes	☐ Never
Going downstairs?	☐ Usually	☐ Sometimes	☐ Never
Carrying schoolbooks?	☐ Usually	☐ Sometimes	☐ Never
Getting up from a chair or the floor?	☐ Usually	☐ Sometimes	☐ Never
Going to sleep?	☐ Usually	☐ Sometimes	☐ Never
Staying asleep due to pain?	☐ Usually	☐ Sometimes	☐ Never
Obtaining restful sleep?	☐ Usually	☐ Sometimes	☐ Never
Eating?	☐ Usually	☐ Sometimes	☐ Never
With morning stiffness?	☐ Usually	☐ Sometimes	☐ Never
With changes in the weather?	☐ Usually	☐ Sometimes	☐ Never
Does your child use a cane, crutches, walker, wheelchair or stroller due to his/her illness?	☐ Usually	☐ Sometimes	☐ Never

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Birth History

Birth Weight:	**Birth Length:**	**Vaginal** ☐ **C-Section** ☐
Was your child born premature? ☐ Yes ☐ No	**Gestational Weeks** (number of weeks of pregnancy - average is 40 weeks):	**Length in hospital?**
Were there any abnormalities on the newborn screening? ☐ Yes ☐ No ☐ Unknown		**Born in U.S.?** ☐ Yes ☐ No
Any fetal exposure to drugs, tobacco or alcohol? ☐ Yes ☐ No ☐ Unknown		
Any problems during pregnancy? ☐ Yes ☐ No What problems?		
Did your baby require any special care? ☐ Yes ☐ No What kind of care?		

You do not need to fill in the information in the two rows below. However, it may help in the diagnoses of certain diseases.

Child's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Race: ☐ African American/Black ☐ White ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan

Past Diseases: Has your child had any of these problems? Check all that apply:

Chicken Pox	_____	Rheumatic Fever	_____
Measles	_____	Meningitis	_____
Mumps	_____	Lyme disease	_____
Rubella	_____	Kawasaki disease	_____
Fifth disease/Slapped cheek (Parvo)	_____	Henoch-Schonlein Purpura (HSP)	_____
		Tuberculosis	
Strep Throat	_____		_____
Scarlet Fever	_____		

Immunizations:

Are shots up-to-date?	☐ **Yes** ☐ **No**
Chicken Pox Vaccine Date:_____	☐ **Yes** ☐ **No**

Menstrual:

Have menstrual periods started?	
Age when periods started: _____	☐ **Yes** ☐ **No**
Irregular periods?	
Recent missed periods? How many days apart:_____	☐ **Yes** ☐ **No**
Date of last period: _____	

Surgical/Hospitalization History

Fracture:	**Date/Body Part:**
Fracture:	**Date/Body Part:**
Surgery:	**Date/Reason:**
Surgery:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**
Hospitalization:	**Date/Reason:**

Travel/Vacation

Travel out of country? ☐ **Yes** ☐ **No** **When/where**_____

Has your child had a tick bite? ☐ **Yes** ☐ **No** **When/where (state/country)**_____

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Has your child had any of these problems? (check all that apply)

General:		**Skin:**		**Nervous System:**	
Recent weight loss	Amount_____	Rash	____	Headaches	____
Recent weight gain	Amount_____	Redness	____	How often?	____
Growth problem	____	Hives	____	Dizziness	____
Fatigue	____	Easy bruising	____	Fainting	____
Change in appetite	____	Lumps/bumps	____	Change in behavior	____
Increased sleeping	____	Stretch marks	____	Seizures	____
Increased thirst	____	Color changes	____	Sensitivity or pain of	
Weakness	____	Sun sensitive (allergy)	____	hands and or feet	____
Difficulty sleeping	____	Tightness	____	Memory loss	____
Not rested after sleep	____	Nodules/lumps/bumps	____	Changes in school	
Night sweats	____	Hair loss	____	performance	____
Fever	____	Finger/toenail problem	____		
Maximum temp: _____					
Number of days: _____					
Eyes:		**Ears/Nose/Throat:**		**Heart and Lungs:**	
Pain	____	Ringing	____	Chest pain	____
Redness	____	Loss of hearing	____	Irregular heart beat	____
Swelling around eyes	____	Discharge from ears	____	Heart murmur	____
Vision loss	____	Frequent infections	____	Difficulty breathing	____
Double vision	____	Ear pain	____	Cough	____
Dryness	____	Nose Bleeds	____	Wheezing	____
Feels something in eye	____	Loss of Smell	____	Asthma	____
Sensitive to bright light	____	Runny Nose	____	Allergies	____
		Sore Throat	____	Sinus Infections	____
		Difficulty Swallowing	____	Shortness of breath	____
		Hoarseness/change in		Sudden change in	
		voice	____	heart beat	____
Kidney/Urine/Bladder:		**Mouth:**		**Blood:**	
Trouble going to pee?	____	Gum problems	____	Anemia	____
Pain/burning while peeing?	____	Sores in mouth	____	Bleeding tendency	____
Blood in pee	____	Loss of taste	____	Blood clots	____
Cloudy/dark pee	____	Cavities	____	Sickle Cell Disease	
Going pee often	____	Jaw pain or locking	____	or Trait	____
Bedwetting	____				
Genital sores	____				
Discharge from penis/vagina	____				
Testicular Pain	____				
Urinary Tract Infections	____				
Stomach and Intestines:		**Endocrine:**		**Immunity:**	
Stomach pain	____	Diabetes	____	Serious or too	
Liver problem	____	Type_____		frequent infections	____
Bloody or black stools	____			(list type)	____
Yellow/jaundice	____	Thyroid Disease	____		____
Stomach swelling	____	Type_____		Established Immune	
Constipation	____			Deficiency (list type)	____
Diarrhea	____	Growth Problems	____		____
Vomiting	____	Puberty		Recurrent Fevers	____
Nausea	____	Delayed Onset	____		
GERD/Reflux	____	Advanced Onset	____		

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Family History

Birth Mother (Name):		Age:	Health Problems:
Birth Father (Name):		Age:	Health Problems:
Sibling: ☐ Full ☐ Half (Name)	Sex:	Age:	Health Problems:
Sibling: ☐ Full ☐ Half (Name)	Sex:	Age:	Health Problems:
Sibling: ☐ Full ☐ Half (Name)	Sex:	Age:	Health Problems:
Sibling: ☐ Full ☐ Half (Name)	Sex:	Age:	Health Problems:
Sibling: ☐ Full ☐ Half (Name)	Sex:	Age:	Health Problems:

Do you have any blood relatives who have had: (check which ones and write the relative's relationship to your child)

____	Serious illness in childhood	Relationship to child:
____	Arthritis (type:)	Relationship to child:
____	Ulcerative colitis or Crohn's disease	Relationship to child:
____	Tuberculosis (TB)	Relationship to child:
____	Thyroid disease	Relationship to child:
____	Ankylosing spondylitis	Relationship to child:
____	Back pain	Relationship to child:
____	Lupus or "SLE"	Relationship to child:
____	Scleroderma	Relationship to child:
____	Sarcoidosis	Relationship to child:
____	Raynaud's (color changes in hand/feet in cold)	Relationship to child:
____	Bleeding tendency or sickle cell disease	Relationship to child:
____	Diabetes	Relationship to child:
____	Psoriasis	Relationship to child:
____	Gout	Relationship to child:
____	Dermatomyositis/polymyositis	Relationship to child:
____	Multiple sclerosis	Relationship to child:
____	Muscle disease/Muscular dystrophy	Relationship to child:
____	Celiac Disease	Relationship to child:
____	Other major illness	Relationship to child:

Social History

Mother's job: Father's job:	Is your child in daycare? ☐ Yes ☐ No	Does your child smoke? ☐ Yes ☐ No Number of cigarettes/day_____
Who lives in the home?	Is your child in school? ☐ Yes ☐ No	Does your child drink alcohol? ☐ Yes ☐ No
Recent life changes?	Your child's grades: ☐ A's ☐ B's ☐ C's ☐ Failing	Does your child use drugs? ☐ Yes ☐ No
What does your child like to do outside of school?	Does your child take part in PE? ☐ Yes ☐ No	Is your child sexually active? ☐ Yes ☐ No # of partners in last 12 mos._____
Is your child missing school? ☐ Yes ☐ No How many days has s/he missed this term?	Does your child take part in after school sports? ☐ Yes ☐ No Which sports? _____	Does child use birth control? ☐ Yes ☐ No Type_____

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Allergies

Medicine Allergies: ☐ No ☐ Yes List:

Food Allergies: ☐ No ☐ Yes List:

Medicines (Please list all of your child's current medicines)

Medicine (oral & injectable) Please list the name of each medicine your child takes	**How much does your child take?**	**How often does your child take it?**	**How does your child take this medication?**	**Why does your child take this medication?**	**When was the last dose of this medication given?**

Source of information: ☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐ **Other:** _____

I have reviewed the list above and to the best of my knowledge, these are the medicines that the patient is currently taking.

Parent/Patient/Legal Guardian Signature: _____ **Date:**_____ **Time:**_____

Provider/Physician Signature: _____ **Date:** _____ **Time:** _____

Resident/Fellow Signature: _____ **Date:** _____ **Time:** _____

Preferred Pharmacy: _____ **Phone:** _____

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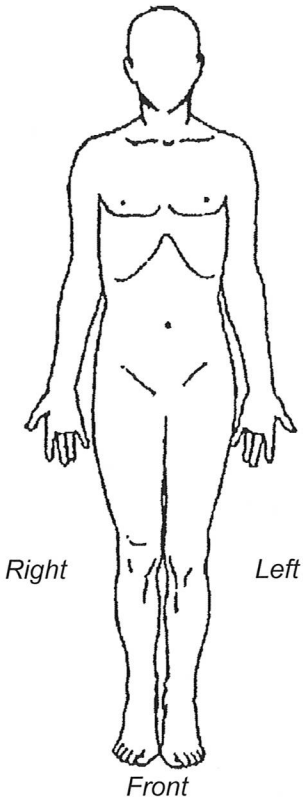
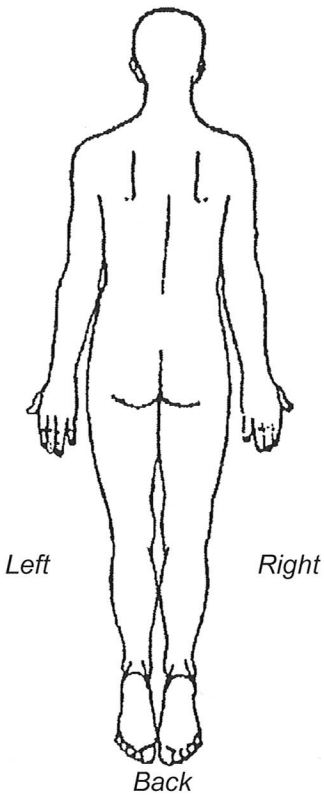
Pain and function:

If your child is in pain now, where does s/he hurt?

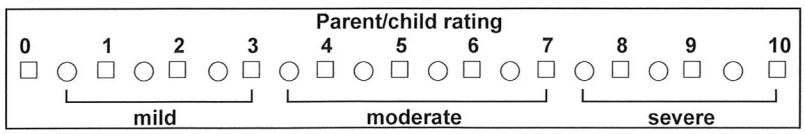
If your child is older than age 8, have him fill out this page.

- Have your child mark the areas on his/her body where he feels pain, numbness, pins and needles, or a burning sensation.
- To finish the picture, have your child draw the face.

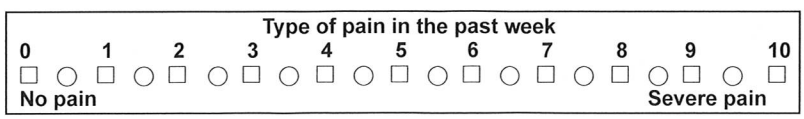




Rate your/your child's level of pain by checking a box below.
(mild = low pain, moderate = some pain, severe = a lot of pain)



Rate your/your child's pain in the <u>past week</u> by checking a box below.



Parent/Patient/Legal Guardian Signature: _____ Date:_____ Time:_____

Reviewed by: _____ Date:_____ Time:_____