34474-08

Children's Healthcare of Atlanta
Children's Physician Group

ALLERGY NEW PATIENT INTAKE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent/Guardian:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once finished.

1. The patient has the following allergic symptoms (Select all that apply)
   ☐ nasal congestion ☐ nasal drainage ☐ post nasal drip ☐ nasal polyps ☐ nasal itchiness ☐ snoring
   ☐ mouth breathing ☐ bad breath ☐ nose bleeds ☐ sneezing ☐ itchy eyes ☐ red eyes ☐ eye discharge
   ☐ fatigue ☐ headaches ☐ cough up phlegm ☐ cough/choke with eating ☐ reflux symptoms ☐ hives
   ☐ eyelid swelling
2. These things cause the patient's symptoms (Select all that apply)
   ☐ dust ☐ pollen ☐ cut grass ☐ raked leaves ☐ mold/mildew ☐ mustiness ☐ dog ☐ cat ☐ feathers
   ☐ other animals ☐ exercise ☐ spring ☐ summer ☐ fall ☐ winter ☐ indoors ☐ outdoors ☐ home
   ☐ workplace/school ☐ strong odors (perfume, cleaners) ☐ temperature changes
   ☐ weather changes (rain, wind, cold, heat) ☐ daytime ☐ nighttime ☐ smoke ☐ emotional upset ☐ cold or virus
   ☐ food
3. In the past year, the patient has (Select all that apply)
   ☐ been to the emergency room/urgent care ☐ taken oral steroids (i.e. prelone, prednisone)
   ☐ been admitted to the hospital ☐ been admitted to the ICU ☐ had a procedure/surgery
   ☐ used a nebulizer or inhaler
4. The patient's living situation includes (Select all that apply)
   ☐ house ☐ apartment ☐ mobile home ☐ other
   ☐ heated by: gas ☐ heated by: wood ☐ heated by: electric ☐ heated by: other
   ☐ cooled by: central air ☐ cooled by: window unit ☐ cooled by: open windows ☐ cooled by: other
   ☐ flooring: carpet ☐ flooring: wood ☐ flooring: vinyl ☐ flooring: other
   ☐ pests: cockroach ☐ pests: mice ☐ pests: other
   ☐ water leaks: yes ☐ water leaks: no
   ☐ smoking: yes ☐ smoking: no ☐ pets: dog ☐ pets: cat ☐ pets: other
5. The patient sleeps with stuffed animals ☐ yes ☐ no
6. Changes have been made to the patient's home including (Select all that apply)
   ☐ pillow covers ☐ mattress covers ☐ removed carpet ☐ dehumidifier ☐ extermination ☐ other
7. The patient has eczema ☐ yes ☐ no
8. The patient has reactions to insects ☐ yes ☐ no
9. The patient has reactions to food(s) ☐ yes ☐ no
10. The patient gets frequent infections ☐ yes ☐ no
11. The patient has been tested for allergies ☐ yes ☐ no
12. The patient has/does receive allergy shots ☐ yes ☐ no
13. If the patient has asthma, please list the Asthma Control Test score: _____

Parent/Guardian signature	Reviewed by	Date	Time

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Children's Physician Group

SOCIAL HISTORY

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once finished.

Please check all that apply when answering the questions below:

1. Patient accompanied to appointment by: (choose all that apply)
   ☐ Mother ☐ Father ☐ Foster parents/guardian ☐ Siblings ☐ Grandparents
   ☐ Other _____

2. Lives with: (choose all that apply)
   ☐ Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
   ☐ Cousin(s) ☐ Foster parent(s) ☐ DFCS ☐ Other _____

3. Legal custody: (choose all that apply)
   ☐ Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle
   ☐ Cousin ☐ Foster parent(s) ☐ DFCS ☐ Other _____

4. Number of siblings:
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐ Other _____

5. Mother's occupation: _____

6. Father's occupation: _____

7. Pets/Animals (choose all that apply)
   ☐ None ☐ Cats ☐ Dogs ☐ Other _____

8. Additional activities outside of school (choose all that apply)
   ☐ Sports ☐ Arts ☐ Religious activities ☐ Other _____

9. Stressors (choose all that apply)
   ☐ None ☐ Illness/Death ☐ Money ☐ Multiple moves ☐ Parents ☐ School/Bullying
   ☐ Transportation ☐ Other _____

10. Grade Level
    ☐ None ☐ Daycare ☐ Medically Fragile Daycare ☐ Preschool ☐ Kindergarten ☐ 1st grade
    ☐ 2nd grade ☐ 3rd grade ☐ 4th grade ☐ 5th grade ☐ 6th grade ☐ 7th grade ☐ 8th grade
    ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ 12th grade ☐ College ☐ Special Accommodations

_____ _____ _____ _____
Parent/Guardian signature Reviewed by Date Time

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GENERAL INTAKE
REVIEW OF SYSTEMS

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait.

Please check all that apply when answering the questions below:

1. Does the child have any of the following issues? (choose all that apply)
   ☐ No problems ☐ Weight changes ☐ Fatigue ☐ Sleep problems ☐ Fever ☐ Other

2. Does the child have any problems with his/her eyes (choose all that apply)
   ☐ No problems ☐ Pain/discomfort ☐ Difficulty seeing ☐ Wears glasses/contacts

3. Does the child have any problems with his/her ears, nose, and throat? (choose all that apply)
   ☐ No problems ☐ Hearing difficulty ☐ Snoring ☐ Runny nose ☐ Ear infection/pain ☐ Noisy breathing
   ☐ Sore Throat ☐ Ear pain/pulling

4. Does the child have any heart problems? (choose all that apply)
   ☐ No problems ☐ Chest pain ☐ Irregular/skipped heart beats ☐ Passing out

5. Does the child have any problems with his/her breathing? (choose all that apply)
   ☐ No problems ☐ Cough ☐ Difficulty breathing ☐ Wheezing

6. Does the child have any gastrointestinal (stomach) problems? (choose all that apply)
   ☐ No problems ☐ Changes in appetite ☐ Stomach pain ☐ Diarrhea ☐ Constipation
   ☐ Difficulty swallowing ☐ Nausea/vomiting

7. Does the child have any urinary problems? (choose all that apply)
   ☐ No problems ☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Bedwetting/nighttime urination

8. Does the child have any skin problems? (choose all that apply)
   ☐ No problems ☐ Dry skin/eczema ☐ Rash

9. Does the child have any neurological problems? (choose all that apply)
   ☐ No problems ☐ Headaches ☐ Weakness ☐ Dizziness ☐ Numbness/tingling ☐ Developmental delay

10. Does the child have any psychological (emotional) problems? (choose all that apply)
    ☐ No problems ☐ Mood changes ☐ Behavioral problems

11. Does the child have any hematological (bleeding) problems? (choose all that apply)
    ☐ No problems ☐ Easy bruising ☐ Anemia ☐ Swollen lymph nodes

12. Does the child have any endocrine problems? (choose all that apply)
    ☐ No problems ☐ Increased thirst ☐ Heat/cold intolerance

13. Does the child have any musculoskeletal problems? (choose all that apply)
    ☐ No problems ☐ Arm/leg pain ☐ Joint swelling ☐ Leg swelling

_____	_____	_____	_____
Parent/Guardian signature	Reviewed by	Date	Time

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REVIEW OF SYSTEMS

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PATIENT IDENTIFICATION

For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat

Pain Score	Pain Scale

Staff Signature: _____ Date: _____ Time: _____