PATIENT INFORMATION

(Minor Patient)

PATIENT NAME_____Birthdate.:_____ SEX_____

(Medicare/Medicaid only) S.S #: _____-_____-_____

MOTHER'S NAME_____ FATHER'S NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____ CELL PHONE_____

FAMILY EMAIL _____

REASON FOR OFFICE VISIT:_____

WHEN DID THIS BEGIN?_____

HOW DID THIS HAPPEN/WHAT WERE YOU DOING?_____

IF PAIN, DESCRIBE (CIRCLE): SHARP, DULL/ACHY, VARRYING, TRAVELS, CONSTANT

RATE THE PAIN 0-10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN YOU COULD IMAGINE:_____

SINCE THE PROBLEM STARTED, IS IT: (CIRCLE) ABOUT THE SAME, GETTING BETTER, GETTING WORSE

WHAT MAKES IT WORSE:_____ BETTER:_____

IT INTERFERES WITH: (CIRCLE) WORK/SCHOOL, SLEEP, WALKING, HOBBIES/SPORTS, OTHER:_____

OTHER DOCTORS SEEN FOR THIS PROBLEM:_____

TREATMENT(S) RENDERED?_____ OUTCOME?_____

HAVE YOU HAD X-RAYS, MRI, OR A CT?_____

CURRENT HEALTH PROBLEMS/CONCERNS:_____

_____

_____

MEDICATIONS:_____

_____

_____

CURRENT SUPPLEMENTS:_____

MAJOR HOSPITALIZATIONS/SURGERIES/INJURIES, (INCLUDE YEAR AND OUTCOME)

_____

_____

_____

HAS THE PATIENT HAD ANY MAJOR FALLS SINCE BIRTH?_____ STICHES OR A FRACTURE?_____

ANY CAR ACCIDENTS?_____TYPE OF ACCIDENT?_____WAS ANYONE INJURED?_____

PLEASE CHECK ALL THAT APPLY:

☐ WEAKNESS	☐ EARACHES	☐ HEAD INJURY	☐ HEADACHES
☐ COUGH	☐ ASTHMA	☐ DIZZINESS	
☐ FAINTING	☐ SEIZURES	☐ CONSTIPATION	☐ DIARRHEA

HEALTH HABITS (PER DAY)

EXERCISE/SPORTS: ☐ 5-7 DAYS/WK ☐ 3-4 DAYS/WK ☐ 1-2 DAYS/WK ☐ NONE

TYPE:_____HOURS PER SESSION:_____

WEIGHT OF SCHOOL BACKPACK_____

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AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED:_____ RELATIONSHIP:_____ DATE:_____