Sayana Medical
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Pediatric/Adolescent Health History Intake Form

Last Name:_____ First Name:_____ Middle Name:_____

Date of Birth:_____ Age:_____ Sex:_____ Today's Date:_____

Pediatrician/ Primary Care Provider: _____ *(Please note: Having a pediatrician is required.)*

Address: _____ Phone #: _____

PRENATAL/BIRTH HISTORY

A. Mother's Pregnancy: □Normal □Complications:_____
B. Gestation:_____weeks
C. Birth Location: □Hospital □Birthing Center □Home □Other_____
D. Delivery: □Vaginal □C-Section…..Any Complications: □No □Yes_____
E. Birth Weight:_____lbs_____oz…..Length:_____inches

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1._____

2._____

3._____

4._____

PAST MEDICAL HISTORY

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 2._____ 3. _____

4. _____ 5. _____ 6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____

2. Environment:_____

3. Food:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age_____	Ear Infections:	No	Yes/How often:_____
ADD:	No	Yes/Age_____	Eating Disorders:	No	Yes/Age and type:_____
ADHD:	No	Yes/Age_____	Eczema:	No	Yes/Age:_____
Alcohol use:	No	Yes/How often:_____	Head lice:	No	Yes/Age:_____
Allergies:	No	Yes/Age_____	Molluscum contagiosum:	No	Yes/Age:_____
Asthma:	No	Yes/Age_____	Mononucleosis:	No	Yes/Age:_____
Bedwetting:	No	Yes/Age_____	Obesity/Overweight:	No	Yes/Age:_____
Behavior problems:	No	Yes/Age_____	Pink eye:	No	Yes/Age:_____
Bronchitis	No	Yes/Age_____	Pneumonia:	No	Yes/Age:_____
Colic:	No	Yes/Age_____	Colds:	No	Yes/How often:_____
Constipation:	No	Yes/How often:_____	Sinus Infection:	No	Yes/How often:_____
Cough:	No	Yes/How often:_____	Thrush:	No	Yes/Age:_____
Croup:	No	Yes/Age_____	Vomiting:	No	Yes/Age:_____
Depression	No	Yes/Age_____	Whooping cough:	No	Yes/Age:_____
Diaper rash:	No	Yes/How often:_____	Other:	Age:_____	Illness:_____
Diarrhea:	No	Yes/How often:_____	Other:	Age:_____	Illness:_____

IMMUNIZATIONS: (Please place an **X** in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail)

	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS/SURGERIES: (Indicate reason and date)

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY-Con't

LABS AND EXAM HISTORY: Please indicate date and results.

Date of last well child check:_____ Results: □ Normal □ Other _____

Date of last blood work:_____ Results: □ Normal □ Other _____

Date of last urine test:_____ Results: □ Normal □ Other _____

Adolescents:

Date of last PAP and pelvic exam:_____ Results: □ Normal □ Other _____

FAMILY HISTORY: Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									
Tuberculosis									

SOCIAL HISTORY

Parent's Marital Status: □ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Mother's Occupation:_____Father's Occupation:_____

Guardian's Occupation:_____

Daycare Location:_____

Days/Hours per week:_____

SOCIAL HISTORY-Con't

BIRTH CONTROL:
Adolescents:
What form of contraception/birth control are you using (Check all that apply).
□ Abstinence □ Withdrawal □ Fertility Awareness Method □ The Sponge □ Spermicide □ Condom □ Diaphragm □ Cervical Cap □ IUD □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch □ Vasectomy □ None

PERSONAL HABITS: Identify any substances you have used and circle whether in the past (P) or are currently using (C)
Adolescents:
Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?

□ Tobacco: P C Freq:_____ □Recreational Drugs: P C Identify type/Freq:_____
□ Alcohol: P C Freq:_____ □Other: P C Specify/Freq:_____
□ Coffee: P C Freq:_____

EXERCISE:
Toddlers/Adolescents:
Do you exercise regularly? □ Yes □ No
If you checked yes to exercising regularly, answer the following questions: What type/activity?_____
How long?_____ How Often?_____

SLEEP:
How many hours of sleep do you get at night on average?_____
Toddlers/Adolescents:
How often do you wake and for what reasons?_____
Do you have any trouble falling asleep? □ No □ Yes/Why?_____
Do you have trouble waking up? □ No □ Yes/Why_____
Do you wake rested? □ Yes □ No/Why _____

ENERGY AND STRESS:
Adolescents:
How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?_____
How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?_____
How do you cope with stress?_____

NUTRITIONAL HISTORY
Infant/Toddlers:
Type: □Nursing □Formula/Specify_____ □Both
Frequency: □Every hour □Every other hour □Every 3rd hour □Every 4th hour □Every 5th hour □Other_____
Duration: □<15 min □15-30 min □30-45 min □45-60 min
Amount per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz
Adolescents:
What is a typical breakfast?_____
What is a typical lunch?_____
What is a typical dinner?_____
What are typical snacks?_____
How many glasses of water do you drink each day on average?_____
Do you have any special dietary restrictions?_____

Patient Information

Date:_____

Last Name:_____First Name:_____Middle Name:_____

Date of Birth:_____Sex:_____SS#:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_(_____)_____Work Phone:_(_____)_____Cell Phone:_(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? □ No □ Yes

(Specify): □ Home □ Work □ Cell

Email:_____Emergency Contact/Relation:_____Contact's Phone:_____

Referral Source: □ Referred by:_____ □ Insurance Provider List □ Sayana Medical's Website
□ Internet

Mother's Name:_____

Father's Name:_____

Benefits and Billing Information

I. Primary Insurance Company & Plan Name:_____

ID Number:_____Group/Policy #_____

Name of Policy Holder:_____Policy Holder's Date of Birth:_____

Relationship to Policy Holder:_____Is Your Primary Insurance Policy: □ POS □ PPO □ EPO □ HMO

Payment Policies

All visit fees are due and payable at each visit. You are responsible for all lab costs that may not be covered by insurance.

- Initial Visit Fee: $280
- Subsequent Visit Fee: $180
- Venipuncture fee: $25
- Late Cancellation Fee for Initial (First) Visit: $150
- No Show Fee: $50 *(Missed appointment that was not canceled or rescheduled 24 hours prior to appointment).*

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative OR Guardian

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Informed Consent for Treatment

I, _____, hereby authorize Dr. Sandy Le & Sayana Medical medical providers to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Common diagnostic procedures: venipuncture, Pap smears, radiography, laboratory, x-ray, stool and salvia testing.
Contraception
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Immunization
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Minor office procedures: dressing a wound, ear cleansing.
Psychological Counseling
Pharmaceutical prescriptions

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed pharmaceuticals, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Sandy Le & Sayana Medical medical providers regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Dr. Sandy Le & Sayana Medical medical providers to the best of their ability.

_____ _____
Date Signature of Patient

_____
Signature of Patient Representative OR Guardian