Riverside Pediatrics Integrative Medicine Intake

Name of patient _____

Date of birth _____ Health insurance carrier _____

Parents' Names _____

Cell phone (parent) _____ (patient)_____

Email (parent)_____ (patient)_____

Best way to get in touch with parent_____ patient_____

How did you hear about Riverside Pediatrics? _____

How did you hear about Integrative Medicine at R.P.? _____

If patient is over 18: Do you give consent for us to discuss your care with your parents? Y/N

The following questions are about the patient

Reason(s) for coming in today - be as specific as possible

_____

_____

_____

Anything that you have found helpful?

_____

Current Medications and supplements, include doses

_____

_____

Who lives at home? If multiple homes please list approximate % time at each

_____

_____

School _____ Grade _____ Average grades_____

Extracurricular activities _____

List hobbies, activities , work_____

Past Medical History - serious illnesses, surgeries

_____

_____

Family History that you think is relevant to patient's concern

_____

Diet: please write down a typical day's diet - be as specific as possible
Breakfast _____
Lunch _____
Dinner _____
Snacks during day _____
Snacks in evening _____
Beverages _____

Do you drink (check all that apply and estimate number/day)

__ Coffee, amount _____
__ Soda, amount _____ What type _____
__ Alcoholic drinks, _____ per day_____ per week What type _____

Do you smoke cigarettes? Y/N Number of cigarettes/day ____

Do you smoke marijuana? Y/N Number of times per week _____

Do you or have you ever used other recreational drugs? _____ Type _____

Do you practice any of the following? Check all that apply. Please specify how often/type. Also please ***indicate whether you are interested in any of these modalities? Y/N/maybe***

__ Meditation _____ interested _____
__ Yoga _____ interested _____
__ Spiritual/religious _____ interested _____
__ Martial arts _____ interested _____
__ Aromatherapy _____ interested _____
__ Acupuncture _____ interested _____
__ Regular exercise _____ interested _____
__ Breath work _____ interested _____
__ Chiropractic _____ interested _____
__ Other _____ interested _____

If we offered group visits for patients with similar issues as yours would you be comfortable attending? Y/N/Maybe Please say why or why not

_____

Do you have a therapist? _____ Did you ever?_____ Interested?_____

Name of therapist _____

What do you see as barriers for YOU to achieve the outcome you desire?

_____

What would you say is the best thing(s) in your life/ gives you the most support and joy?

_____

_____

What is your goal for today's meeting? _____

_____

Write down in an informal way, without worrying about grammar, what a "best possible scenario" would be for you. If you felt completely healthy and happy what would that look like? What would be able to do that you are not doing now?

_____

_____

_____

_____