AMBERWOOD TERRACE
INTEGRATED HEALTH

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CHILD NEW PATIENT INTAKE FORM

Please complete the ENTIRETY of this form.

Patient Name (First, Middle initial and Last) _____

DOB: _____ Sex: ☐ M ☐ F SSN: _____ - _____ - _____

Street Address: _____ City, State, Zip: _____

Cell Phone: _____ Email Address: _____

How did you hear about us? _____

Emergency Contact Name and Relation: _____

Emergency Contact Phone Number: _____

Current Health Condition:

Chief Complaint (Why are you here today?): _____Date of Onset: _____

Have you seen any other physician for this condition? If yes, who? _____

Since onset, has anything helped you? If yes, what? _____

Are you currently taking any prescription medications? Please list. _____

Are you currently taking any supplements? Please list. _____

Please list any allergies (drug, non-drug, sensitivities, etc.): _____

Are you currently under Chiropractic care? If yes, who is your DC? _____

How would you describe your diet? ☐ POOR ☐ ADEQUATE ☐ GOOD ☐ EXCELLENT

Please list any dietary restrictions. _____

How would you describe your sleep quality? ☐ POOR ☐ ADEQUATE ☐ GOOD ☐ EXCELLENT

How many hours each night, typically? _____

How much screen time are you exposed to each day? ☐ MILD ☐ MODERATE ☐ EXCESSIVE

Please list any sports/hobbies. _____

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Complete Health History:

Have you ever had any surgeries or procedures? Please list. _____

Please list any previous injuries. _____

Please circle all that apply.

EYE/VISION- ☐ **NONE**	**BLINDNESS, WEAR GLASSES OR CONTACTS, CATARACTS, ITCHING, GLAUCOMA, TEARING**
NERVOUS SYSTEM- ☐ **NONE**	**DIZZINESS, MEMORY LOSS, LOSS OF CONSCIOUSNESS, NUMBNESS, SLEEP DISTURBANCE, STROKES, WEAKNESS, SEIZURES, HEADACHES, TREMORS**
EAR, NOSE AND THROAT- ☐ **NONE**	**BLEEDING, SNORING, SMELL LOSS, TASTE LOSS, SORE THROAT, SINUS OR EAR INFECTIONS, CONGESTION, TINNITUS, DIFFICULTY SWALLOWING**
CARDIOVASCULAR- ☐ **NONE**	**CHEST PAIN, HEART MURMUR, ORTHOPNEA (DIFFICULTY BREATHING LYING DOWN), SWELLING OF LEGS, ULCERS, VARICOSE VEINS, PALPITATIONS**
RESPIRATION- ☐ **NONE**	**ASTHMA, COUGHING UP BLOOD, COUGH, WHEEZING, SPUTUM PRODUCTION, SHORTNESS OF BREATH**
GASTROINTESTINAL- ☐ **NONE**	**ABDOMINAL PAIN, DIARRHEA, HEARTBURN, JAUNDICE, INDIGESTION, CONSTIPATION, RECTAL BLEEDING, ABNORMAL STOOL, HEMORRHOIDS, VOMITING**
ENDOCRINE- ☐ **NONE**	**COLD OR HEAT INTOLERANCE, EXCESSIVE APPETITE, DIABETES, EXCESSIVE THIRST OR HUNGER, HAIR LOSS, VOICE CHANGES, GOITER**
SKIN- ☐ **NONE**	**CHANGES IN NAIL TEXTURE OR SKIN COLOR, HIVES, ITCHING, RASH, SKIN LESION/ ULCER, NUMBNESS, TINGLING, PRICKLING**
PSYCHOLOGICAL- ☐ **NONE**	**ANHODENIA, MOOD CHANGES, MEMORY LOSS, ANXIETY, BIPOLAR DISORDER, CONVULSIONS, CONFUSION, DEPRESSION, INSOMNIA**
ALLERGY- ☐ **NONE**	**ANAPHYLAXIS, ITCHING, FOOD INTOLERANCE, SNEEZING, NASAL CONGESTION**
HEMATOLOGY- ☐ **NONE**	**ANEMIA, BLOOD CLOTTING, BRUISES EASILY, BLEEDING, BLOOD TRANSFUSION(S), FATIGUE, LYMPH NODE SWELLING**
FEMALE- ☐ **NONE**	**BIRTH CONTROL, BREAST LUMP, CRAMPS, VAGINAL DISCHARGE, BURNING URINATION, HORMONE THERAPY, IRREGULAR MENSTRUATION**
MALE- ☐ **NONE**	**BURNING URINATION, IRREGULAR URINATION, HESITANCE/DRIBBLING, PROSTATE PROBLEMS**

Childhood Illnesses: ☐ I deny any childhood illness(es) Other: _____

ADD ADHD Allergies Anemia Asthma Bed-wetting Cerebral Palsy

Chicken Pox Diabetes Ear Infections Eczema Headaches Measles Mumps

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Immunizations: ☐ I deny any immunizations Diphtheria, Tetanus and Pertussis TB Chicken Pox Hepatitis A Hepatitis B Hepatitis C Influenza Polio Measles, Mumps & Rubella Pneumococcal Small Pox Whooping Cough COVID-19

Please list any Family health history (Mother, Father, Grandparents and siblings) relating to cancer, heart, diabetes, kidney, autoimmune, psychiatric conditions: _____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient/Parent Name: _____ Signature: _____Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose and carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date: _____

ATIH Staff Name: _____ Signature: _____ Date: _____

Written Consent for a Child, AGE 18 AND YOUNGER

Name of patient who is a minor/child _____

ATIH
AMBERWOOD TERRACE
INTEGRATED HEALTH

I authorize Sylvia Zakusilov, RN MSN NP-C and any and all Amberwood Terrace Integrated Health staff to perform diagnostic procedures, radiographic evaluations, renders care and perform treatment to my minor/child.

As of this date, I have the legal right to select and authorize healthcare services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Amberwood Terrace Integrated Health.

Guardian Signature _____ Date:_____

ATIH Staff Signature: _____Date: _____