Pediatric New Patient Intake Form

We will soon have this form as an online jotform, but in the meantime, please TYPE the information below (if possible) and return this form to: newclientintake@realhealthmedical.com Within a few days after this form is submitted, you will receive an email from our new patient coordinator with the offer of an appointment including our recommendations and cost estimates for the first visit. There is no need to call the office to schedule the initial appointment as you will receive the initial correspondence regarding scheduling via email. Thank you for your patience and we look forward to serving you soon.

Date:

Name:

Gender:

Birth date:

Age:

Address, City & State:

Email:

Phone:

Parent / Spouse / Guardian:

Referral source:

MEDICAL HEALTH

Description of your child's symptoms:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Date of onset of symptoms:

Did something trigger your child's change in health?

List current medical diagnosis:

What would you as a parent like to accomplish for your child by coming to Real Health Medical?
List your child's specific health goals:

1.
2.
3.
4.
5.

Describe any serious illnesses:

Describe any surgeries:

Describe any hospitalizations:

Describe your child's immediate family health history:

List current medications your child is taking:

List current supplements your child is taking:

Describe any benefit that you have noticed from a specific supplement

List any types of testing or treatments you are interested in discussing:

ALLERGIES
History of anaphylactic allergy reactions?

Allergies to Medications:

Allergies to Food:

Allergies / Reactions to Environment (inhalants, chemicals)

VACCINATIONS / IMMUNIZATIONS

Up to date on vaccination schedule? (Y / N)

COVID vaccination? (Y / N):
COVID vaccine Brand:

Date of COVID vaccine:

Describe any COVID vaccine reaction / side effects:

Partially vaccinated

Vaccines declined

PHYSICAL BODY TRAUMA / SCARS / PAIN

Does your child have any scars? Y / N

If yes, where on their body, and details of the event:

How many concussions has your child experienced?

Does your child have structural problems? (*scoliosis for example*)

Describe any chronic or recurrent pain:

Which of the following has your child used and benefited from :

chiropractic adjustments
osteopathic adjustments
massage therapy
craniosacral therapy
myofascial release
acupuncture
injections - trigger point
injections - steroids
injections - prolozone
injections - stem cell / PRP / exosomes

TREATMENTS/ THERAPIES

List other treatments / therapies your child has used in the past that are relevant to their current health concerns:

Has there been a prolonged use of anti-inflammatory medication (Advil, Motrin, Aspirin, etc)

Yes

No

Has there been any prolonged use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc)?

Yes

No

Has there been a frequent use of antibiotics >3 times/year?

Yes

No

Has your child used steroids (prednisone, nasal/asthma inhalers in the past?

Yes

No

Does your child currently or in the past use contraceptives?

Yes

No

Has your child taken antidepressants, antipsychotics, stimulants or ADHD medication before?

Yes

No

DENTAL HEALTH

Child has cavities now or in the past

Mercury fillings

Root canals

Tooth pain

Bleeding gums

Gingivitis

Chewing problems

Does your child floss regularly?

Yes

No

HORMONE/ ENDOCRINE

Any history of low thyroid ?

Any family history of low thyroid?

Any other hormone or endocrine hormone issues?

LIFESTYLE / METABOLIC INFORMATION

Your child's current Energy Level - 1 to 10 (10 being highly energetic)

Your child's current level of wellness - 1- to 10 (10 being optimal)

Blood Type:

Height:

Weight:

What weight do you consider to be healthy for your child ?

How many pounds would your child need to LOSE to be at their ideal body weight?

How many pounds would your child need to GAIN to be at their ideal body weight?

DIETARY NUTRITION / DIGESTIVE

Does your child follow a specific type of diet? (ie keto, vegan)

Please describe your typical breakfast, lunch and dinner:

Does your child experience any food reactions?

Does your child crave any particular foods?

How much water does your child drink daily:

What other drinks does your child consume?

Do you think your child needs to make any dietary nutrition changes?

Describe any digestive / GI problems your child has or is

experiencing?

REST

Average number of hours of sleep per night:

Does your child have difficulty going to sleep?

Does your child have difficulty staying asleep?

Are they refreshed on waking?

Does your child snore?

Do they need any sleep aids?

Do you think you need to make any changes that relate to rest?

EXERCISE

Describe your child's activity level:

Do you think they need to make any activity changes?

Is your child enrolled in any sports? If so, which ones?

How much time does your child spend on screen activities per day? (ie TV, video games, phone, etc)

SOCIAL/FAMILY/ FRIENDS

How many family members does your child have?

Does your child live in multiple homes?

How many pets are in your household?

Is your child able to make friends?

Has your child experienced any major life changes that may have impacted his/her health?
Has your child ever experienced any major losses or trauma? If so, please explain.

Has your child ever been the victim of abuse or crime?

STRESS

Does your child feel stressed? If so list stress sources:

1.
2.
3.
4.
5.

What stress coping strategies does your child utilize?

Does your child struggle with any addictions?

Does anyone in your child's household smoke?

Has your child been exposed to or used street drugs or alcohol?

LEARNING ENVIRONMENT

My child attends:

Public School

Private School

Home School

Charter School

How is your child's academic performance?

Failing classes

Has IEP plan

Is in special education program

Is in gifted education program

Has 504 plan

Any behavioral problems in school?

PREVIOUS FUNCTIONAL / NATUROPATHIC TESTING & TREATMENT

What functional medicine or natural health practitioner (s) has your child seen?

Year/ Major finding:

Describe and treatments:

Describe your level (percentage) of improvement:

Have you been tested by CHA or Computerized Health Assessment (Quest, Zyto,, BioScan)?

If yes, date and clinic of last CHA assessment?

GENETIC / GENOMIC TESTING

Have you had Genomic - genetic testing? example MTHFR

Any significant genetic abnormalities?

LABORATORY / RADIOLOGY

Date of most recent CT Scan, MRI ?

Date of most recent laboratory testing (Month / Year)

Please email lab or radiology reports that would be helpful in your assessment to:
frontdesk@realhealthmedical.com

APPOINTMENT & FINANCIAL INFORMATION

New patient appointments often require fasting for blood work and are scheduled earlier in the day. What day/s of the week are you most available in the mid-morning to come to our clinic for your initial appointments?

We are a cash pay practice, but can bill insurance for lab work ONLY. Please note that our office does not bill insurance for services other than lab work and we are unable to provide billing and CPT codes for services.

Health Insurance Company Name/Provider: Deductible Met:

If you would like for your labs to be covered by your insurance, you MUST contact your insurance company to determine IF there is a specific lab vendor designated by your health insurance company. **If the incorrect lab is used, an expensive lab bill may be incurred.**

What is the name of the lab vendor associated with your insurance company: (Quest, LabCorp, etc ?)