Osher Center for Integrative Medicine
Pediatric Integrative Medicine Clinics General Intake Form
1545 Divisadero St., 4th Floor
San Francisco, CA 94115
415 353-7720 phone
415 353-7358 fax

WELCOME

We are looking forward to seeing you and finding effective ways to help you and your child. Thank you for taking the time to fill out the information below in as much detail as possible. We anticipate it may take approximately 15-30 minutes to complete depending on the complexity of the problems. It will help us gather the information we need and make the best use of our time together. **Please return this form before your appointment**. Please also include any medical reports or other evaluations that you feel are relevant which would also be very useful to help us in our assessment.

Because we perform an in-depth evaluation, the entire initial assessment usually takes place over two one-hour sessions about 1-3 weeks apart. There may be laboratory tests done in the interval. Often, sensitive issues are best discussed without the child in the room. If you feel this may be an important part of your visit and your child needs more supervision than a safe waiting room, please plan to have an additional caretaker come to the appointment. Please let us know if you are unable to do this. We have toys, books and a DVD player available. If your child has favorite items that will be helpful, please feel free to bring them.

PATIENT INFORMATION

Child's Name: _____ Form Completed by: _____

Child's preferred Pronouns: _____ Relationship to Child: _____

Child's Date of Birth: _____ Date Completed: _____

Child's Age: _____ Child's Gender: ☐ Male ☐ Female ☐ Transgender ☐Non-binary Pronouns:

Primary Care Physician: _____ **Referred by**: _____

City, State: _____ City, State: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

FAMILY INFORMATION

Families come in many forms. Please use the two columns below for the child's parent(s) and/or main caregivers. This could be the biological parents, step parent(s), same sex parents, grandparent(s), etc.

	Parent	**Parent**
Name		
Address		
Home Phone		
Work Phone		
Cell Phone		
Email		
Ethnicity/Primary Language		
Education Level & Occupation		

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SPECIALISTS WORKING WITH YOUR CHILD
Please list the names for all medical specialists and therapists who are or have worked with your child

1.

2.

3.

4.

5.

Please check those additional therapies your child currently receives. Provide contact information if available

Speech Therapy ☐
Occupational Therapy ☐
Physical Therapy ☐
Homeopathy ☐
Acupuncture ☐
Osteopathic manipulation ☐
Other ☐

MAJOR DIAGNOSES OR PROBLEMS THAT YOU WOULD LIKE ADDRESSED: (i.e. ADHD, pain problem, Autism, behavior concerns, headaches, etc.)

QUESTIONS YOU WOULD LIKE ANSWERED:

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USE THE FOLLOWING SPACE TO DESCRIBE YOUR CHILD IN AS MUCH DETAIL AS YOU WOULD LIKE.
Please include any factors that you think are relevant. This is a chance to tell his or her story to help us get a sense of who your child is. You can have your child participate as well.

CURRENT HEALTH PROBLEMS
Check any that apply

Abdominal pain	☐	Behavior problems	☐
Diarrhea	☐	Developmental delay	☐
Constipation	☐	Attention difficulties	☐
Urinary problems	☐	Anxiety	☐
Asthma	☐	Sleep problems	☐
Allergies	☐	Headaches	☐
Eczema	☐	Learning differences	☐
Seizures	☐	Other	☐

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PAST MEDICAL HISTORY
Check any that apply

Abdominal pain	☐	Behavior problems	☐
Diarrhea	☐	Developmental delay	☐
Constipation	☐	Attention difficulties	☐
Urinary problems	☐	Anxiety	☐
Asthma	☐	Sleep problems	☐
Allergies	☐	Headaches	☐
Eczema	☐	Learning differences	☐
Seizures	☐	Other	☐

ALLERGIES
List any medications your child is allergic to and type of reaction.

List any foods you believe or suspect your child is allergic to and type of reaction.

List any environmental that your child is allergic to and type of reaction (i.e. trees, grass, perfume, cleansers).

FAMILY MEDICAL HISTORY
Please check all medical conditions that have occurred in the child's immediate relatives (parents, grandparents, siblings and half-siblings, aunts, uncles and cousins). Name relationship to child in the space provided.

	No	Yes	Mother's Family	Father's Family
Gastrointestinal problems (IBS, Reflux…)	☐	☐	_____	_____
Learning Disability	☐	☐	_____	_____
Attention Deficit Disorder (ADHD)	☐	☐	_____	_____
Mental Retardation	☐	☐	_____	_____
Congenital Syndromes	☐	☐	_____	_____
Autism or Autistic Spectrum Disorder	☐	☐	_____	_____
Chronic Illness	☐	☐	_____	_____
Chronic Pain	☐	☐	_____	_____
Thyroid disease	☐	☐	_____	_____
Depression	☐	☐	_____	_____
Allergies	☐	☐	_____	_____
Diabetes	☐	☐	_____	_____
Asthma	☐	☐	_____	_____
Anxiety	☐	☐	_____	_____
Obsessive compulsive Disorder	☐	☐	_____	_____
Alcohol or chemical Dependency	☐	☐	_____	_____
Other	☐	☐	_____	_____

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PATIENT'S MEDICATIONS (CURRENT AND PAST)

Name of medication	What is (was) it used for?	Dosage & Frequency	How long has it been used? Or, reason it was stopped

VITAMINS, HERBAL REMEDIES, OR HOMEOPATHIC MEDICINE (CURRENT AND PAST)

Name of remedy/vitamin	What is (was) it used for?	Dosage & Frequency	How long has patient used?

Describe any hospitalizations of the child:

Describe any surgeries your child has had:

BIRTH HISTORY

Please describe any problems during pregnancy or with delivery. Were there any problems right after birth? Did you breastfeed and if so for how long?

SLEEP

Does your child experience any of the following difficulties with **sleep**?

☐ Difficulty falling asleep ☐ Waking in the night ☐ Night terrors ☐ Sleeps too much
☐ Nightmares ☐ Early morning waking ☐ Falls asleep during day ☐ Restless Leg Syndrome
☐ Snoring ☐ Not well rested upon awakening

_____ Average hours of sleep at night
_____ Time child goes to bed
_____ Time child goes to sleep
_____ Hours of sleep during the day
_____ Time child wakes up

EATING/NUTRITION

Do you have any of the following concerns about your child's **eating/nutrition**?

☐ Poor food choices ☐ Avoids foods due to texture
☐ Overeats ☐ Skips meals

Is your child on a special diet?

Please describe your child's typical diet:

Breakfast

Lunch

Snacks

Dinner

_____ Number of caffeine drinks per day (Pepsi, coffee, etc.)
_____ Number of sugar drinks per day (Pop, Juice, etc.)
_____ Number of chocolate servings per day (candy bar, etc.)
_____ Number of sugar servings per day (cookie, etc.)
_____ How many times week does your child eat in a restaurant?
_____ How many times/week does your child eat "fast food"?

EXERCISE/ACTIVITY

Do you have any of the following concerns about your child's exercise/activity?

☐ Excessive physical activity ☐ Limited physical activity ☐ Lack of interest in physical activity

How many hours per week does your child exercise?

How much time does your child spend outdoors each day?

How many hours/day does your child spend in front of any type of screen (TV, video games, computer, other)?

SCHOOL INFORMATION

School Name: _____ Grade: _____

Address: _____ Has your child ever repeated or skipped a grade: ☐ No ☐ Yes Grade: _____

Teacher(s): _____ School/Guidance Counselor: _____

Phone: _____ Fax: _____

How many days of school has your child missed **this academic year**? _____

How many days of school has your child missed **last academic year**? _____

Has your child had a school evaluation due to special learning needs? ☐ No ☐ Yes

Does your child have an Individualized Education Plan (IEP)? ☐ No ☐ Yes

Does your child have a 504 Plan? ☐ No ☐ Yes

Describe specific concerns about your child's school, grades, or classmates:

OTHER SOCIAL AND FAMILY HISTORY

Who lives in the house with your child?

Have there been any recent significant stressful events in your child's life:

How does your child do socially with other children? With adults?

What makes your child?

Happy

Sad

Angry

Stressed

Quality of Life
How good or enjoyable is your life?

	0=Worst									10=Best
Parents' current quality of life:	0	1	2	3	4	5	6	7	8	9	10
Child's current quality of life:	0	1	2	3	4	5	6	7	8	9	10
Family's current quality of life:	0	1	2	3	4	5	6	7	8	9	10

PLEASE ADD ANY ADDITIONAL INFORMATION TO HELP US UNDERSTAND YOUR CHILD'S CONDITION: