



Pediatric Health History

Today's Date: _____

Patient's Full Name: _____ Date of Birth: ____/____/____

Gender: _____ Primary Language: _____ Race: _____

Primary Contact Information:

Mailing Address:

Street: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone (please circle): Cell / Home / Other

Cell: _____ Home: _____ Work: _____

Is it ok to leave a detailed message at your preferred phone number? (circle one) yes / no

Can your preferred phone receive text messages? Yes / No

Preferred Email Address: _____

Is it ok for us to email you with general updates related to Seek Optimal Health, P.C.? (circle one) yes / no

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

Health Insurance Details:

Type (please circle all that apply):

Medicare / Medicaid or Medi-Cal / Group Health Plan / Other

Insurance Plan: _____ Insurance Company: _____

Employer / School Name: _____

Are you currently on Medical Disability? Yes / No

Do you receive any Medicare benefits? Yes / No

Referral Source:

Did anyone refer you to Seek Optimal Health, P.C.? (please be specific: include name of website, friend, etc): Yes / No

Referral Source: _____

Other Healthcare Providers:

Primary Care Physician: _____ Facility/Clinic: _____

Phone: _____

Other Provider(s) involved in your care (Physician Specialists, Chiropractor, Naturopath, Acupuncturist, Homeopath, Dentist, etc):

Please read the following Agreements and Initial After Each if you Agree:

Complimentary Care Agreement

While the services offered at Seek Optimal Health, P.C. are meant to help you improve your overall health and well-being, they are not intended to take the place of a relationship with a primary care provider who offers standard recommended screening services (mammograms, pap smear, prostate exams, etc). I understand that the care I receive from Seek Optimal Health, P.C. is considered complimentary. I further understand that in order to receive care from the providers at Seek Optimal Health, P.C. I must maintain a relationship with a primary care physician of my choosing and that no physician at Seek Optimal Health, P.C. may function as my primary care physician. Initial: _____

Payment Agreement

I understand that I am solely responsible to pay for services rendered by Seek Optimal Health, P.C. according to the fee schedule discussed at the time of scheduling my first appointment (As of 07/01/2019, our initial visit fee for the Santa Cruz office is \$495 for adults, 30 min follow-ups are \$195 and 60 minute follow-up are \$390). The basic office visit fee does include osteopathic manipulation but other office procedures offered are not included in this fee (injections, laser therapy, etc). Nutritional supplements are also not included in the visit fees and must be purchased separately. Initial: _____

I understand that payment is due at the time of service. I also understand that I can request a superbill from Seek Optimal Health, P.C. that I may submit to my insurance for reimbursement. I am responsible for any fees incurred by Seek Optimal Health, P.C. as a result of a returned or cancelled check. Initial: _____

HIPAA

I confirm that I have been offered a copy of a Notice of Privacy Practices for Seek Optimal Health, P.C. I also acknowledge that a copy of any amendments to the Notice of Privacy Practices will be available at each appointment or upon request. Initial: _____

Informed Consent for Treatment with Osteopathic Manipulation

Osteopathic manipulative medicine is based on the following tenets: The body is a unit; the person is a unit of body, mind, and spirit. The body is capable of self-regulation, self-healing, and health maintenance. Rational treatment is based upon an understanding of the basic **principles** of body unity, self-regulation, and the interrelationship of structure and function.

Osteopathic manipulative treatments involve application of manual (hands-on) techniques centered in an understanding of functional anatomy. In general, they are both specific and gentle. Associated risks are minimal, and commonly benign.

Potential benefits of Osteopathic manipulative treatment include reduction of pain or discomfort, greater flexibility and strength, restoration of symmetry, improvement in numbness or tingling, reduction of swelling, enhancement of the body's natural healing mechanisms, and improvement in function of the body's organ systems.

Osteopathic manipulative treatment is generally painless and well tolerated. Occasionally, people do experience some temporary pain during application of the manual techniques depending on the dysfunctions present. Bruising is possible after certain techniques. Mild soreness lasting one to two days after treatment is possible, and is usually considered a normal part of the healing process. It is also common to have some temporary mild drowsiness or a lightheaded feeling immediately following treatment. Risks are extremely rare in skilled hands, but could include fracture, disc herniation, or rupture of a blood vessel. As in the practice of any form of medicine, other unexpected risks or complications may occur.

If, during the course of treatment, unforeseen conditions are discovered it may be necessary to alter or discontinue osteopathic manipulative treatment.

I acknowledge that I have read the above description about osteopathic manipulative treatment, and understand the possible risks and benefits of osteopathic manipulative treatment. I will inform the physician providing treatment at Seek Optimal Health, P.C. of any conditions I have been diagnosed with that might affect the treatment's outcome. I understand that no guarantee can be made as to the results that may be obtained with osteopathic manual therapy, or to the number of visits required for a desired outcome, since patient response is individual. I voluntarily give my authorization and consent to receive osteopathic manipulative treatment by the physicians at Seek Optimal Health, P.C.. Initial: _____

Primary Reasons for Scheduling Today's Visit:

1. _____
2. _____
3. _____

Do you have any medical records (labs or imaging studies) that would be helpful in our evaluation of your current reason for scheduling? Please be sure to send anything pertinent to us via the online patient portal. If you are unable to access the portal, you can fax them to us at (855) 225-6308.

Medical History (Medical conditions patient has been diagnosed with / treated for):

Current Medications (Please include dose and frequency):

Current Nutritional Supplements/Vitamins (Please include brand, dose, and frequency):

Allergies: (Please list any allergies in the table below, along with type and severity of reaction 1 for mild, 2 for moderate, 3 for severe):

	Type of Reaction	Severity
Medication		
Food		
Environmental		

Trauma History (Mental / Emotional / Falls / Surgeries / Broken Bones / Concussions with dates, please):

Birth History:

Patient born by: Vaginal birth / C-section

Please describe any complications during patient's

birth: _____

Was assistance required? Yes / No If yes, what type? Forceps / Vacuum

Did the patient breastfeed? Yes / No If yes, how long? _____

Was there any difficulty

breastfeeding? _____

Was there any difficulty with bottle

feeding? _____

Did mother receive any of the following medications? (Circle all that apply) pitocin / oral pain meds / epidural / antibiotics

Were there any complications after

birth?: _____

Personal Dental History:

Does patient currently have any amalgam (Silver) fillings? Yes / No / Not Sure

Has patient ever had a root canal? Yes / No

Has patient had dental extractions? Yes / No If yes, please describe:

Has patient had any

freneotomies? _____

Does patient have any of the following? (Circle all that apply) Permanent retainer / Night guard / Braces / Invisalign / ALF

Please specify if you are using dental appliances not mentioned above :

If not currently using, have they had orthodontic braces in the past? Yes / No

Have they ever used a rapid palate expander? Yes / No

Does patient have any of the following conditions? (Circle all that apply): Sleep apnea / Snoring / Bruxism (grinding/ clenching)

Do they have any TMJ problems? Yes / No If yes, please specify: _____

Do they generally receive regular dental exams / cleanings? Yes / No

Women's Health (if applicable):

Menstrual Status (please circle):

Regular cycles / Irregular cycles

Age at first menstrual cycle: _____

General Review of Symptoms (please check all that apply in the tables below):

	Current (past 3 mos)	Past History		Current (past 3 mos)	Past History
Unexplained weight loss			Morning Fatigue		
Unexplained weight gain			Afternoon Fatigue		
Fevers			Trouble Falling Asleep		
Blurred Vision			Trouble Staying Asleep		

Double Vision			Abrupt Vision Changes		
Eye Pain			Hoarseness		
Itchy Eyes			Trouble Swallowing		
Ringing in Ears			Appetite Changes		
Hearing Changes			Bloating		
Post Nasal Drip			Abdominal Pain		
Mouth Sores			Heartburn/Indigestion		
Tooth Pain			Pain with breathing		
Diarrhea			Constipation		
Nausea			Fainting		
Vomiting			Frequent urination		
Food Intolerances			Bedwetting		
Productive Cough			Frequent spitting up		
Dry Cough			Hernia		
Fussiness			Rashes		
Hip Pain			Excessive thirst/hunger		
Neck Pain			Anxiety		
Upper Back Pain			Depression		
Mid Back Pain			Phobias		
Low Back Pain			Dizziness		
Other Joint Pain			Anemia		
Itching			Bleeding tendency		
Acne			Easy bruising		
Mouth breathing			Speech changes		
Neck Swelling			Hayfever		
Trouble with coordination			Hives		

Other:

Who does the patient live with? (Circle all that apply) pets / spouse / partner / extended family / friends / child(ren) / parents

Has the patient or their parents had any long term exposures to either mold or chemicals at home or work? Yes / No

If you answered yes to the above question, please specify: _____

Do they participate in any sports? Yes / No If yes, which sports? _____

Please list any major sources of stress in the patient's life. _____

How do they handle/manage stress? _____

Diet:

How would you describe the patient's current diet? _____

Is the patient a picky eater? _____

Dietary preferences / restrictions: _____

Do they drink any caffeinated beverages? Coffee / Tea / Energy Drinks / Soda / Other: _____

Family History:

Please fill in the table below with pertinent family history, if known:

	Living?	Age if living or age at death	Significant medical diagnoses
Mother	Yes / No		
Father	Yes / No		
Maternal Grandmother	Yes / No		
Maternal Grandfather	Yes / No		
Paternal Grandmother	Yes / No		
Paternal Grandfather	Yes / No		

	How many?	Ages	Are they all alive?	Significant medical diagnoses
Sister(s)			Yes / No	
Brother(s)			Yes / No	

All answers to the questions above provided by me have been true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____

Relationship to the patient:

Self / Parent or legal guardian (patient is a minor) / Adult to whom I have granted rights of medical guardian or conservator