

999 Whitlock Ave Suite 11 Marietta, GA 30064

Today's Date:	A CONTRACTOR OF THE PARTY OF TH
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New Patient Information Form

Please print clearly. Please complete ALL information on the form before your visit today. This allows our doctor to familiarize herself with your case and do any needed research before your visit. Once filled out, please fax it to us at: 770-590-9997 (If there is sufficient time, you can mail it as well.)

mail it as well.)						
Personal Informati	on					
First Name:		Middle II	nitial:	Last Nam	e:	
Address:						
City:			_ State:		Zip:	
Cell:	Но	me:			_Work:	
Email address:			A.12. 2426	and an artist of the second of		
Date of Birth:	Age:	_ Sex:	Male	Female	Height: _	Weight:
Occupation:			Emplo	yer:		
If patient is a minor, p	parent/guardia	n name(s	s):			
Emergency Contact N	ame:			[Phone:	
Referred By (How did	you hear abou	ıt us?): _				
Financial Informat	<u>ion</u>					
Person responsible fo						
Method of Payment:	CashCh	neck	Visa/Ma	ster Card/[Discover/A	American Express
Health History						
List any major illnesse	es or injuries w	ith appro	oximate dat	es:		
Illness or Injury	<u>Date</u>		nplications			Full Recovery
		_			-	
		_			· · · · · · · · · · · · · · · · · · ·	The state of the s
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YOUTH HEALTH HISTORY QUESTIONNAIRE

Name			Today's date:
	Birth Date:		
This questio	nnaire is designed to assist in providi history. Please be as detailed as po		
What is the r	eason for this visit?		
Please list ar	ny known health conditions that your child	has been diagnosed	with:
3. List any med	lications your child is currently taking, or	has taken in the past	
4. Please indica	ate any history of antibiotic use, listing w		nat purpose.
5. Are there an	y known drug allergies?		
6. List supplem	ents, herbs, remedies, including athletic p	performance supplem	ents that your child is currently taking:
7. Do you susp	ect your child to use recreational drugs?	If so, what:	
8. List any hos	oital procedures/surgeries that your child	has had:	

<u>LIFESTYLE INDICATORS</u> (please fill in or circle the appropriate answer)							
1. Does your child consume any of the following?							
Soda	none	< 2 ca	ns / day	> 2 cans / day			
Sweets / Carbs	none	< twice	e / day	> twice / day			
White Flour	none	< twice	e / day	> twice / day			
Milk/Dairy Products	none	< twice	e / day	> twice / day		1	
Juice	none	< twice	e / day	> twice / day			
Meat/Fish	none	rarely		< once a week	every day		
2. How much water does you	r child drink each	day? _					
3. Are there smokers in the c	nild's home?	Yes	No				
Does your child get consistent physical activity?			Yes	No			
5. Please list any regular exercise or sports that your child participates in:							
		Maria National Control					

History (please fill in or circle the appropriate answer)
1. Did your child have colic as an infant? Yes No
2. How was your child fed as an infant? Breast Bottle
What brand / kind of formula?
3. Has your child had any respiratory infections? Yes No
How often?
4. Does your child ever complain of back or neck pain? Yes No
Please explain:
5. Does your child ever complain of arm or leg pain? Yes No
Please explain:
6. Does your child ever complain of headaches? Yes No
How often?
7. Has your child had ear infections? Yes No
Age of the first occurrence and frequency:
8. Do they typically occur in the same ear? Yes No Which ear? Right Left Both
9. Please list any illnesses that your child has had and approximate dates of occurrence:
10. Has your child been vaccinated? Yes No Recently? Yes No
11. Please describe any reactions that your child has had to past or recent vaccinations:
12. Please list any other concerns you have regarding your child's health:

Sleep Habits (please fill in or circle the appropriate answer)							
1. How well does your	child sleep?						
Well Trouble falling asleep			Trouble stay	Trouble staying asleep			
2. Does your child wak	e up tired?	Yes	s No				
3. How many hours do	es your child sleep	on an ave	erage night?			DAME 1	
4. Does your child take	e naps? Yes	No					
5. Does your child have	e nightmares?	No	Sometimes	Often			

For Cycling Females Only (please fill in or circle the appropriate answer)							
Age of onset of menarche (first period):							
Approximate Date:	- was a second of the second o						
2. Is your child currently using any	2. Is your child currently using any method of birth control? Yes No						
What kind? Oral Pill	Injecte	d	Patch	Ring			
3. How long has your child been us	sing birth cor	ntrol?					
4. Please describe any symptoms	that your chi	ld may h	nave experie	enced while u	sing birth control (i.e. yeast		
infections, heavy / light bleeding, m							
		Name of the last o					
First day of last period:	No. of the second second	<u> </u>					
6. Length of typical period:							
7. Is menstrual cycle regular?							
Details:							
8. How many pads and / or tampor	8. How many pads and / or tampons (please circle) are used on heavy days?						
9. Any knowledge of passing clots	? Yes	No					
How often?				- edisse			
10. Any spotting between periods?		Yes	No				
At what point in cycle?							
11. Does your child experience cra		None	Mild	Moderate	Severe		
2 180	At what point in the cycle?						
				W-1			

INSTRUCTIONS: Please mark the following symptoms as they apply. Please be as detailed as possible.

Please be as detailed as possible.						
SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	MORE INFORMATION		
Low Mood						
Lowered Self-Esteem		1				
Discouragement				360C 1 30C 2017		
Sadness / Crying				ent. (pages :		
Reserved / Withdrawn						
Decreased Interest in Activities						
Decreased Initiative / Motivation						
Behavior Problems						
Aggression						
Anger						
Anxiety						
Fear						
Difficulty Concentrating						
Foggy Thinking						
Memory Problems						
Constant Hunger						
Never Hungry / Anorexia						
Weight Loss						
Weight gain						
Decrease in Strength / Stamina						
Decrease in Athletic Performance	AIIMO MANDRESM					
Fatigue						
Anemia						
Headaches / Migraines						
Body / Joint / Backaches						
Digestive Problems						
Irritable Bowel						
Constipation						
Loose Stool / Diarrhea		X(4)				
Bloating						
Frequent Urination						
Bedwetting						
Allergies						
Asthma						
Throat Clearing						
Excessive Mucous / Runny Nose	(i)					
Dry Skin		1				
Acne		1				
Cold Sores		1				
Infections / Lowered Immunity						