

Patient Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

About your daughter... (for parents/caregivers only)

What about her makes you proud? _____

What seems to be the greatest challenge for her? _____

Anything else you would like us to know? _____

What is the main reason for the appointment today? _____

Please understand that most insurance companies do not pay for care of problems and preventive / wellness care provided on the same day. The patient is responsible for additional fees if this applies. Please let us know if you would like to schedule a separate appointment on a different day to better meet your needs.

Annual Exam (well-check) _____

Physical Symptoms _____

Nutrition, Body Image _____

Social, Emotional, Mood Concerns _____

Risk Behaviors, Safety _____

Sexuality, Gynecology _____

Medication questions, refills needed _____

For New Patients Only

Previous primary care physician(s) _____

Purpose of appointment is to establish ongoing primary care consult about a problem

How did you hear about us? Physician: _____ GTW Patient Community Friend Program Internet

Treatment Team

On-going Primary Care Provider: GTW Other: _____

Medical Specialists _____

Psychiatrist _____

Counselor/Therapists _____

Mental Health or Educational Testing _____

Other _____



Patient Medical History If established patient, note any NEW info or NO CHANGES _____				
Allergy/Asthma/Imm <input type="checkbox"/> asthma <input type="checkbox"/> seasonal allergies <input type="checkbox"/> food allergies <input type="checkbox"/> frequent infections <input type="checkbox"/> immune deficiency	Dermatology <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> psoriasis <input type="checkbox"/> cancerous moles or melanoma	Gastroenterology <input type="checkbox"/> irritable bowel syndrome <input type="checkbox"/> reflux or GERD <input type="checkbox"/> chronic constipation <input type="checkbox"/> Crohn's or ulcerative colitis <input type="checkbox"/> celiac disease	Endocrine <input type="checkbox"/> thyroid disorder <input type="checkbox"/> diabetes type 1, insulin dependent <input type="checkbox"/> diabetes type 2, non-insulin dependent <input type="checkbox"/> PCOS	Infectious Disease <input type="checkbox"/> chicken pox <input type="checkbox"/> mononucleosis <input type="checkbox"/> pneumonia
Cardiovascular <input type="checkbox"/> heart murmur <input type="checkbox"/> heart problems <input type="checkbox"/> fainting or dizziness with exercise <input type="checkbox"/> abnormal heart rhythm <input type="checkbox"/> blood clot <input type="checkbox"/> high cholesterol <input type="checkbox"/> high blood pressure	Orthopedic <input type="checkbox"/> broken bones <input type="checkbox"/> arthritis <input type="checkbox"/> scoliosis	GYN/Urology <input type="checkbox"/> urinary tract infection <input type="checkbox"/> kidney problems <input type="checkbox"/> severe menstrual cramps <input type="checkbox"/> ovarian cyst(s) <input type="checkbox"/> sexually transmitted infection <input type="checkbox"/> pregnancy	Neurodevelopmental <input type="checkbox"/> birth complications <input type="checkbox"/> developmental delay <input type="checkbox"/> genetic disorder <input type="checkbox"/> speech or language delay <input type="checkbox"/> learning disorder <input type="checkbox"/> autism <input type="checkbox"/> Asperger's <input type="checkbox"/> ADD/ADHD	Neuropsychology <input type="checkbox"/> migraines <input type="checkbox"/> tics <input type="checkbox"/> seizures <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> eating disorder <input type="checkbox"/> drug use <input type="checkbox"/> tobacco use

Patient Medical History If established patient, note any NEW info or NO CHANGES _____

Recent Exams/Labs _____ Approx Date: ___/___/___
 Major Injuries _____ Approx Date: ___/___/___
 Surgeries _____ Approx Date: ___/___/___
 Hospitalizations _____ Approx Date: ___/___/___
 Immunization Status Up to Date Not sure

Family Life If established patient, note any NEW info or NO CHANGES _____

Who does patient live with most of the time?	Occupation (if applies)	Part-time	Full-time
<input type="checkbox"/> Mother		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Father		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Step-Mother		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Step-Father		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brother(s)	Ages: _____		
<input type="checkbox"/> Sister(s)	Ages: _____		
<input type="checkbox"/> Other:			

If patient lives in more than one home, what are the custodial arrangements? _____

FAMILY MEDICAL HISTORY If established patient, note any NEW info or NO CHANGES _____				
Mother	Father	Siblings	Grandparents	Other (explain)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders	<input type="checkbox"/> Bleeding or clotting disorders
<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia	<input type="checkbox"/> Blood disorders or sickle cell anemia
<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke	<input type="checkbox"/> Heart attack/stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> PCOS	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> PCOS	<input type="checkbox"/> PCOS	<input type="checkbox"/> PCOS
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Obesity	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Obesity	<input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer (type)	(_____)	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Cancer (type)
(_____)	<input type="checkbox"/>	(_____)	(_____)	(_____)
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY MENTAL HEALTH History If established patient, note any NEW info or NO CHANGES _____				
Mother	Father	Siblings	Grandparents	Other (explain)
<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Learning disability
<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide	<input type="checkbox"/> Suicide
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse	<input type="checkbox"/> Alcohol/drug abuse
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Stressors/Changes or NO significant stressors/changes _____

- New School
- Recent move
- Deployed parent
- Family financial or legal problems
- Parental job loss
- Parental conflict or divorce
- Illness/death in family
- Death of friend

Who is completing this form? Patient Mother Father Other: _____



