Napa Valley Osteopathic Medicine
Saskia Lytle-Vieira, D.O.

PEDIATRIC NEW PATIENT INFORMATION

Patient Name_____
First Middle Last

Parent(s)/Guardian(s) Name:_____

Patient Birth Date: _____

Address_____

City_____State_____Zip_____

Please place an * asterisk * by your preferred contact number:

Home Phone_____Mobile Phone_____Work Phone _____

Email_____

Emergency Contact_____Relationship_____Phone_____

How did you hear about us? _____

Pediatrician's Name _____

Pediatrician's Phone Number_____

May we leave messages about your child's health information via phone? ☐ yes, phone #_____☐no

Has your child ever received osteopathic treatment before? no yes if yes, Dr's name:_____

Date of last osteopathic treatment: _____

Patient Name: _____

Medical History:
For each of your concerns/complaints, please fill in the table. **Please list the concerns in order of importance to you**. If you have more than 2 issues to list, copy/print this page or the next page as needed for additional issues.

<table>
<tr><td>Concern #1 (example: colic)

_____

What makes it better? (circle)

nothing ice heat rest nursing/eating stretching walking sitting medication massage chiropractic
other _____</td><td>When did it start?

_____

Did your child have a trauma/accident/ fall or other notable event occur around the time this problem began?</td><td>Frequency
(ex) constant, daily

_____

yes no

if yes describe:
_____</td><td>Severity
(ex) mild/mod/severe

_____</td></tr>
<tr><td>What makes it worse? (circle)

nothing ice heat rest nursing/eating stretching walking sitting medication massage chiropractic
other _____</td><td colspan="3"></td></tr>
<tr><td>What testing or procedures has your child had (if any) for this problem? (circle)

X ray MRI CT Scan Surgery

Ultrasound EMG Injections

other_____</td><td colspan="3" rowspan="2"></td></tr>
<tr><td>What were results of these tests/procedures:
_____
_____

Anything else you want the doctor to know about this concern?_____
_____
_____</td></tr>
</table>

Patient Name: _____

Concern #2 _____	When did it start? _____	Frequency _____	Severity _____
What makes it better? (circle) nothing ice heat rest nursing/eating stretching walking sitting medication massage chiropractic other _____	Did your child have a trauma/accident/ fall or other notable event occur around the time this problem began?	yes no if yes describe: _____	
What makes it worse? (circle) nothing ice heat rest nursing/eating stretching walking sitting medication massage chiropractic other _____			
What testing or procedures has your child had (if any) for this problem? (circle) X ray MRI CT Scan Surgery Ultrasound EMG Injections other_____			
What were results of these tests/procedures: _____ _____ Anything else you want the doctor to know about this concern?_____ _____ _____			

Patient Name:_____

Has your child seen a specialist for the problem(s)? (*Ex:, ENT doctor, pain management doctor, neurologist, GI doctor*) yes no If yes, what was diagnosis/treatment plan?

_____
_____
_____
_____

What do you hope your child receives from treatment? (*Ex: be happy and comfortable after eating and sleep better throughout the night")*

_____
_____
_____
_____

What medical conditions does your child have, now or in the past? (please circle)

Abnormal Heart Rhythm	Bleeding Disorder	Eye Problems	Headaches/Migraines
Acid Reflux/Heartburn	Blood Clots	Feeding Problem	Pacemaker
Attention Deficit/Hyperactivity	Cancer_____	Foot Problem	Joint Replacement
AIDS/HIV	Cerebral Palsy	Heart Problem	Pneumonia
Allergies	Chronic Ear Infections	Hepatitis	Sleep Problem
Autism	Colic	Hearing Problem	Skin Problem
Anemia	Constipation	Immune Problem	Stroke
Arthritis	Chronic Diarrhea	Irritable Bowel Syn.	TIA (mini stroke)
Asthma	Drug Dependence	Kidney Problem	Thyroid Problem
Anxiety	Depression	Liver Problem	Torticollis ("wry neck")
Birth Defects	Diabetes	Lung Disease	Vomiting
Breathing Problem	Epilepsy/Seizures	Mental Illness	Walking Problem

Other:_____
_____

For teenage female patients only:
Are you currently pregnant? no yes if yes, how many weeks? _____
Have you ever been pregnant? no yes if yes, how many times? _____
Did you give birth: vaginally c-section

Patient Name:_____

Has your child had any hospitalizations or surgery of **any kind** (including cosmetic)?

What	*When*	*What*	*When*

Has your child had any car accidents of **any kind**?

Year?	*Driver or passenger?*	*Where was car hit?*	*Speed of crash?*	*Child's injuries?*	*Did airbag go off?*
1.					
2.					
3.					
4.					
5.					

Dental History: please circle

Tooth extractions? yes no # teeth out_____ Root Canals? yes no
Orthodontia? (braces, retainer) yes no Dental surgery? yes no

Night guard/bite plate? yes no top or bottom teeth?

Prenatal/Birth History: please circle

Was child exposed to alcohol, tobacco, or other drugs while in utero? yes no explain:
_____

Was labor induced? yes no if yes, what drug was used? _____

How long in labor: _____

Did child have "fetal distress" during labor? yes no

Do you know your child's Apgar scores at birth? at one minute_____at five _____

Was child born vaginally c-section

Did you hold your child at birth? yes no

Did your child cry vigorously at birth? yes no

Did your child have any breathing problems at birth? yes no

Did your child need resuscitation at birth? yes no

Was there bruising on child's face or head at birth? yes no

Was child's head "conehead" or other shape at birth? yes no
explain:_____

Was child put in intensive care or other special care at birth? yes no
explain:_____

Was child breech or other uncommon presentation at birth? yes no
explain:_____

Were any of the following used during delivery: suction/vacuum extractor forceps

Was episiotomy used? yes no

Did mother have any medication during labor and delivery? yes no

Was child full term? (38-42 weeks) yes no

Was child premature? no yes if yes, # weeks premature _____

What was child's birth weight? _____

While your child was in utero, did the mother have any surgeries, accidents/falls/trauma? yes no
explain:_____

Is/was your child: breast fed bottle fed both

Any difficulty sucking? yes no

After your child's birth were you ever told that the delivery was particularly difficult or that your child almost died at birth? no yes if yes, please explain_____
_____
_____
_____

Has your child ever:
Broken any bones? yes no which one(s)? _____
_____

Patient Name: _____

Had any head trauma? yes no
explain:_____
_____

Any other injuries/accidents not already mentioned on this form: _____
_____

Have you been told that your child has one leg shorter/longer than the other? no yes if yes L or R

History of scoliosis? yes no

Please list any prescription medications your child is **currently taking**:

Medication *Ex. Cipro*	Reason *Ear Infection*	When started *2 weeks ago*	Dosage *2 tsp once daily*

Does your child have any allergic reactions to medications?

Medication	Reaction/ Intolerance

Please list any supplements, vitamins, or herbs your child is **currently taking:**

Brand and name (manufacturer) *Ex. Flintstones Vitamin*	Reason *Pediatrician Recommended*	Year Started *2010*	Dosage *One tab daily*

Patient Name:_____

Has your child been vaccinated? yes no

Have you noticed any changes in your child after having received a vaccine? yes no if yes, explain:

_____

Are vaccinations up to date? yes no

Date of last visit to pediatrician: _____

Is your child meeting developmental milestones as per your pediatrician? yes no if no, explain: _____
_____
_____

Any concerns from child's teacher, non parent caretaker, etc regarding functioning, learning or behavior issues? _____
_____
_____

Family History: *If any blood relative has suffered any of the following, please indicate which relative.*
Allergies_____Asthma_____Anemia_____Arthritis_____Alcoholism_____
Blood Disorder_____Cancer_____Diabetes_____Epilepsy_____
Glaucoma_____Genetic Disease_____Gout_____Headaches_____
Heart Attack_____High Blood Pressure_____Kidney Problem_____Liver Problem_____
Mental Illness_____Neurological Problem_____Stroke_____
Tuberculosis_____Other_____

Current diet/feeding:_____

Sports/activities:_____

Major life stressors:_____

Patient Name:_____

Review of Systems: Please circle any problems that your child is **currently** having:

General: poor appetite fevers chills weight loss weight gain fatigue/low energy speech problem language problem sleep problem ADD/ADHD learning/reading disability exposure to tobacco smoke

Ears, Nose, Mouth, Throat**:** frequent colds stuffy nose headaches jaw clicking teeth problems grinding teeth chewing problems facial pain sore throat mouth sores bad breath ringing in ears nosebleeds postnasal drip sinus problems trouble with taste/smell hearing problems earaches other:_____

Muscles, Bones, and Joints: neck pain back pain muscle pain painful joints joint swelling muscle weakness muscle cramps numbness tingling
other:_____

Digestion & Intestine: diarrhea constipation abdominal pain/discomfort belching swallowing problem heartburn (GERD) liver problems vomiting gas rectal pain hemorrhoids blood in stool black stools change in bowel habits nausea other _____

Eyes: crossed eyes eye pain blurry vision wear glasses/contacts poor day/night vision other:_____

Heart and Circulation: chest pain heart murmur lightheadedness palpitations cold hands/feet fainting swelling in feet or ankles blood clots varicose veins
other:_____

Breathing and Lungs: shortness of breath wheezing/asthma frequent colds/flu cough
other:_____

Skin, Hair, Breasts: breast lumps or pain breast leaking fluid skin rashes itching/hives hair loss dry skin/eczema other:_____

Nerves, Movement, Brain: seizures nerve pain balance problem tremors/shaking numbness other:_____

Urine, Kidney, Bladder: painful urination waking up a lot to urinate kidney stones trouble controlling urine frequent urination blood/pus in urine frequent urinary tract infections other:_____

Immune System: frequent infections environmental sensitivity allergies
other:_____

Blood: swollen lymph glands anemia easy bruising other:_____

Psychological well being: frequently uncooperative/defiant difficulty getting along with others anxious or depressed mood hospitalization for psychiatric issue
other:_____

Reproductive System: genital sores lumps/swelling other:_____

Female Reproductive System: pelvic pain vaginal discharge painful periods PMS itching
other:

With whom does child live? *(Include everyone living in home: adults, children, relatives, and pets.)*

Name	Age	Relationship	Name	Age	Relationship

Is there anything else you want the doctor to know? _____

_____

_____

Please read and sign at the bottom:
I am requesting osteopathic consultation and treatment for my child from Saskia Lytle-Vieira, DO. I understand that Dr. Lytle-Vieira is a board certified physician specializing in osteopathic manipulative medicine/neuromusculoskeletal medicine. I understand that while she is fully licensed to practice medicine in the state of California, Dr. Lytle-Vieira's practice is a specialty practice devoted to consultations for osteopathic manipulative treatment in the management of the full spectrum of a patient's healthcare needs. I understand that her practice does not include the primary management of medical conditions of a chronic nature or routine "screening"/checkups, or the prescription or supervision of long term chronic medications. I understand that Dr. Lytle-Vieira is not on call and does not admit patients to the hospital. I understand that Dr. Lytle-Vieira is not a primary care physician/pediatrician, and I agree that I will seek treatment from a qualified primary care provider/pediatrician for my child's ongoing healthcare needs, routine checkups and bloodwork, and long-term medication prescription management. By signing below, I state that I understand the above and agree to its terms.

_____ _____

Signature of parent(s)/guardian(s) Date