Frontier Health and Wellness, LLC

Patient History Questionnaire (Pediatric/Under Guardianship)

To better assist our providers, we are asking that you complete the following questionnaire prior to your initial appointment. If you need more space, please feel free to add pages as needed.

Patient Name:				Date of B	irth:		Form C	ompleted By:		
Please provide a list of	your o	:hild's p	revious (last 5	years) and cu	irrent med	lical and	l mental heal	th providers:		
Provider T				ler Name			oital Name	Phone Numb	per L	ocation (City/State)
Pediatrician		N/A				_				
Previous Pediatrician	ı(s) (las	st 5								
years)		N/A								
Specialist(s) (Cardio,	Neur	ο,								
Allergy, Pulmonolog										
Specialist(s) (Cardio,	Neur	0,								
Allergy, Pulmonolog	y etc.)	N/A								
Therapy		N/A								
Psychiatry		N/A								
Neuropsych Testing		N/A								
Other:										
Other:										
Please list all your child	l's med	lication	s they are curre	ntly taking:	N/A					
Medication Name		Dosage	<u>*</u>	Freque		ncy		for how long?	Side ef	ffects/concerns?
			-	1				9		,
		-								-
				·						
Please list all of your ch	ild's n	revious'	lv taken psychi	atric medica	tion: N/	Α.				
Medication Name	mas p.	Dosage		Frequ		Λ	Taking	for how long?	Side ef	ffects/concerns?
Wiculcauon ivanic		Dosage	<u> </u>	Frequ	CHCy		1 aking 1	ioi now iong.	Side ci	iccs/concerns:
Dlassa listall summlans		41	4		.:1.3 :	414-1	L:			
Please list all suppleme	inus/ov					renuy tai			0.1	<u>m . / </u>
Medication Name		Dosage	e	Frequ	ency		Taking	for how long?	Side et	ffects/concerns?
Dl 1'-4	1. *1			11 41		41 4 .		1		
Please list any of you Allergen	ir chii	u s kno	own allergies	Severity o			occurs: No		pe of Rea	
Allergen			Mild		derate		Severe	1 y	pe or Kea	icuon
			Mild		derate		Severe			
			Mild		derate		Severe			
			Mild		derate		Severe			
			Wild	IVIO	derate		Severe			
Current or previous	subst	ance II	se: N/A							
Substance	Jubst	unce u	30. 14/11		1	requen	cy of Use			
Caffeine		Daily	Weekly	1-2x mc			onally/Socia	lly Tried it	once or t	twice Never
Tobacco/Vaping		Daily	Weekly	1-2x mc			onally/Socia	_	once or t	
Alcohol		Daily	Weekly	1-2x mc			onally/Socia		once or t	
Opioids/		Daily	Weekly	1-2x mc			onally/Socia		once or t	
Prescription Drugs	١''''	Juny	ccmy	1 2x 1110		CCasi	Jimiy/ Joura	, rrequ	once or t	20
Marijuana Marijuana	<u> </u>	Daily	Weekly	1-2x mc	onth 🗀	Occasi	onally/Socia	lly Tried it	once or t	twice Never
Hallucinogens		Daily	Weekly	1-2x mc			onally/Socia		once or t	
Amphetamines		Daily Daily	Weekly	1-2x mc			onally/Socia		once or t	
Other:		Daily	Weekly	1-2x mc			onally/Socia		once or t	
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Frontier Health and Wellness

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Anemia Asthma/Respiratory Concerns Cancer Chronic Fatigue Concussion(s) or TBI Diabetes Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insomnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease sychiatric history: N/A Psychiatric Condition ADHD	Patient	Family	History	Please list the Family Mem	ber(s) affected
Cancer Chronic Fatigue Concussion(s) or TBI Diabetes Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insonnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease sychiatric history: N/A Psychiatric Condition	Patient	Family	History	Please list the Family Mem	ber(s) affected
Chronic Fatigue Concussion(s) or TBI Diabetes Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insomnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease sychiatric history: N/A Psychiatric Condition	Patient	Family	History	Please list the Family Mem	ber(s) affected
Concussion(s) or TBI Diabetes Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insomnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease Sychiatric history: N/A Psychiatric Condition	Patient	Family	History	Please list the Family Mem	ber(s) affected
Diabetes Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insomnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease Eychiatric history: N/A Psychiatric Condition	Patient	Family	History	Please list the Family Mem	ber(s) affected
Epilepsy/Seizures Heart Disease/Condition High Blood Pressure Insonnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease Eychiatric history: N/A Psychiatric Condition	Patient	Family	History	Please list the Family Mem	ber(s) affected
Heart Disease/Condition High Blood Pressure Insomnia Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease Sychiatric history: N/A Psychiatric Condition	Patient or	Family	History History History History History History History History History	Please list the Family Mem	ber(s) affected
High Blood Pressure Insonnia I	Patient Patient Patient Patient Patient Patient Patient Patient Patient or	Family	r History	Please list the Family Mem	ber(s) affected
Stomach/ GI Problems Stroke Substance Abuse Thyroid Disease Sychiatric history: N/A Psychiatric Condition	Patient Patient Patient Patient Patient Patient Patient Patient or Patient	Family Family Family Family Family Family Family Family	History History History History History History History	Please list the Family Mem	ber(s) affected
Stomach/ GI Problems Stroke Substance Abuse Chyroid Disease ychiatric history: N/A Psychiatric Condition	Patient Patient Patient Patient Patient Patient or Patient	Family Family Family Family Family His Family	History History History History History	Please list the Family Mem	ber(s) affected
Stroke Substance Abuse Chyroid Disease ychiatric history: N/A Psychiatric Condition	Patient Patient Patient Patient or Patient	Family Family Family Family His Family	History History History tory	Please list the Family Mem	ber(s) affected
Substance Abuse Chyroid Disease ychiatric history: N/A Psychiatric Condition	Patient Patient Patient or Patient	Family His	History History tory	Please list the Family Mem	ber(s) affected
Thyroid Disease sychiatric history: N/A Psychiatric Condition	Patient or Patient	Family His	History	Please list the Family Mem	ber(s) affected
ychiatric history: N/A Psychiatric Condition	Patient or Patient	Family His	tory	Please list the Family Mem	lber(s) affected
Psychiatric Condition	Patient	Family		Please list the Family Mem	ber(s) affected
Psychiatric Condition	Patient	Family		Please list the Family Mem	ber(s) affected
<u> </u>	Patient	Family		Please list the Family Mem	hber(s) affected
ADHD			History		
111111					
Anger L	Patient Patient		History		
Anxiety [Patient Patient	Family	History		
Bi-Polar Disorder	Patient	Family	History		
Depression [Patient	Family	History		
Inpatient Psychiatric Care	Patient	Family	History		
OCD [Patient		History		
PTSD	Patient		History		
Schizophrenia [Patient		History		
	Patient		History		
Suicide		ганиу	Thistory		
lease list any of your child's surgical h	istory or hosp	vitalizations	N/A		
Surgery/Reason for Hospitalization	Date		Hospital	Doctor/Attending	Location (City, State
Surgery/reason for Trospitalization	Date	J(8)	Поѕрцаі	Doctor/Machanig	
	1				
	1				<u>.I.</u>
as your child had any bloodwork con	mpleted within	n the last 6 i	nonths (if ves. who or	dered the labs to be drawn): \Bullet Yes \Bullet No
as jour sinici ma any prooquorit con	inpleted muni	a are mor or	110111110 (11) 00, 11110 01	gereg are labb to be drawn,	

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