Deborah Pyne, D.O.

Patient Information

Pediatric Intake Forms (0-11 years)

to be completed by a parent or legal guardian

2305 Coit Road, Suite C
Plano, Texas 75075

(972) 733-1955
fax (972) 733-1990

drdebpyne.com
info@drdebpyne.com

Patient Checklist

We are pleased that you have chosen Deborah Pyne, D.O. to consult in your child's medical care. She will be working with you to help you understand their present condition and help achieve your intentions for their improved health.

We ask that you complete and return this packet along with any additional paperwork before you come for their first appointment. You can email the completed forms, fax them to 972-733-1990, upload them here, or drop them off in person.

- [ ] Complete the enclosed forms in their entirety.
- [ ] Collect any relevant test results, x-rays/MRI reports and records. See page 9 for a medical records request form.
- [ ] Make a list of their symptoms and a timeline of these symptoms.
- [ ] Spend a few minutes thinking about your goal for the visit and write down any questions you want answered.
- [ ] Bring their medications and supplements in addition to the written list located on page 12.
- [ ] If they are coming for a musculoskeletal-related problem, wear soft, stretchy clothing like yoga pants or sweat pants.
- [ ] We ask that anyone over the age of 2 who enters the facility wear a mask. KN95 masks are available upon request.
- [ ] If you are not accompanying your child to their appointment, authorization must be provided to allow treatment and approval is required from Dr. Pyne. See page 10 for a consent for treatment form.
- [ ] Please help us maintain a fragrance free atmosphere for our chemically sensitive patients by avoiding cologne, perfume, and scented body products as much as possible on the day of your appointment.

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

I authorize Name/Title: _____

Address: _____

_____

Telephone: _____ Fax: _____

To release my health information to:

Deborah Pyne, D.O.
2305 Coit Road, Suite C
Plano, Texas 75075
T: 972-733-1955 F: 972-733-1990

Type of Information: **please send anything over 10 pages by mail**

- ☐ Complete Medical Records
- ☐ Lab Results Only
- ☐ Progress Notes Only
- ☐ Other _____

Notice: We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: This authorization to release health information is voluntary. This authorization may be revoked at anytime. The revocation must be in writing, signed by you or your representative. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

Name (parent or legal guardian) Signature Date

Consent For Treatment

I give permission for my child _____ to be medically evaluated and treated by Deborah Pyne, D.O. in my absence. I understand that it may be necessary to perform diagnostic test in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

- physician evaluation and consultation
- osteopathic manipulation
- prescriptions and treatment
- laboratory, scoliosis and blood pressure screening
- first aid and emergency care
- referrals to an outside agency for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

_____

☐ My child will be accompanied by:

☐ himself/herself

☐ family member (name): _____

☐ other (name): _____

I give permission for Deborah Pyne, D.O. to share any relevant health information with the person who is accompanying my child.

Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

_____

Name (parent or legal guardian) Signature Date

General Information

Who is completing the forms? ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other Relative ☐ Other ☐ Patient			**Name if other than patient:**
Patient Last Name: **First:** **Middle:**			**Preferred Name:**
Birth Date:	**Age:**	**Sex:** ☐ M ☐ F ☐ Other	**Parent or Legal Guardian Mobile Phone:** ✓ if we may leave messages on this line ☐
Address:			**Patient Mobile Phone:** ✓ if we may leave messages on this line ☐
City: **Zip Code:**			**Home Phone:** ✓ if we may leave messages on this line ☐
Name of all Parents or Legal Guardians:			**Parent or Legal Guardian Work Phone:** ✓ if we may leave messages on this line ☐
How did you hear about our office?			**Parent or Legal Guardian Email Address:** ✓ if you have read the informed consent ☐
Pharmacy: **Phone:**			**Patient Email Address:** ✓ if you have read the informed consent ☐
Emergency Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Primary Care Physician: **Address:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Other Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			

Name Signature Date

Health History

Patient Name:

Birth Date:

List your desired goals by priority:

List current and ongoing conditions or problems:

Weight:

Height:

Date & location of last physical:

Illnesses You've Had:

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer

☐ Chickenpox ☐ COVID-19 ☐ Depression

☐ Diabetes ☐ Glaucoma ☐ Epilepsy

☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure

☐ Kidney Disease ☐ Measles ☐ Mumps

☐ Rheumatic Fever ☐ Rubella ☐ Polio ☐ STD

☐ TB ☐ Thyroid Disease ☐ Ulcer/Reflux ☐_____

Immunizations and most recent date:

☐ COVID-19 _____

☐ Hepatitis A _____ ☐ Hepatitis B _____

☐ Influenza (Flu) _____

☐ HPV _____

☐ Tdap (Tetanus, Diphtheria, Pertussis) _____

☐ MMR (Measles, Mumps, Rubella) _____

☐ Meningococcal _____

☐ Pneumococcal _____

☐ Varicella (Chickenpox) _____

☐ Zoster (Shingles) _____

Allergies (Medications, Food, Environment):

Medication List (include prescribed drugs, over-the-counter medications, vitamins and supplements):

Medication:	Strength:	Dosing:	Medication:	Strength:	Dosing:

List all family members' significant health problems. Include age the problem first occurred:

Mother:

Father:

Sibling:

Sibling:

List past surgeries and hospitalizations:

Incident:	Date:	Reason:	Comments:

List injuries or physical trauma that may be related to pain:

Injury/Trauma:	Date:	Comments:

Has your child undergone any of the following diagnostic studies? Include the date:

☐ Allergy Testing _____ ☐ Echocardiogram _____ ☐ EKG _____

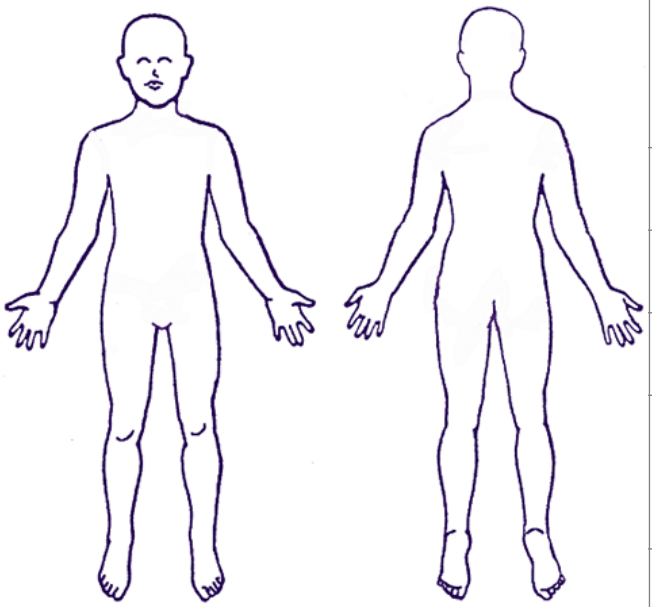
☐ Hearing Screening _____ ☐ Vision Screening _____

☐ CT Scan _____ Part of Body: _____ ☐ X-Ray _____ Part of Body: _____

☐ Ultrasound _____ Part of Body: _____ ☐ MRI _____ Part of Body: _____

Mark specific areas of pain with the following ratings:

1 - mild 2 - moderate 3 - severe



Does your child experience numbness or tingling?

☐ Yes ☐ No Where?

Does your child experience any of the following?

☐ Joint Pain ☐ Joint Stiffness ☐ Joint Soreness

☐ Joint Redness ☐ Joint Heat ☐ Joint Swelling

Where?

Does your child have any specific joint limitations?

☐ Yes ☐ No Where?

Does your child experience morning stiffness?

☐ Yes ☐ No Lasts for _____ hour(s)

Does your child have any lack of flexibility?

☐ Yes ☐ No Where?

List any specific activities that cause pain:

List any treatments tried and their outcome:

Your child's birth was (check all that apply):

☐ Vaginal ☐ C-Section ☐ Full-Term ☐ Pre-Term ☐ Complications:

Please indicate the approximate age for the following milestones:

Sit up	_____ months ☐ Never	Potty trained	_____ months ☐ Never
Roll over, back to front	_____ months ☐ Never	Walk alone	_____ months ☐ Never
Roll over, front to back	_____ months ☐ Never	Sleep through the night	_____ months ☐ Never
Crawl	_____ months ☐ Never	Dry at night	_____ months ☐ Never
Pull to stand	_____ months ☐ Never	First words	_____ months ☐ Never

How does your child FEEL about the following areas of their life?

Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Family: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Friends: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

School: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Eating Habits: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Activities: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Spirituality ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Has your child experienced any major life changes?	**Has your child experienced any major losses?**
Please rate your child's stress levels: ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None	**Does anyone in your household smoke?** ☐ Yes ☐ No
Does anyone in your household drink alcohol? ☐ Yes ☐ No	**Does anyone in your household abuse drugs?** ☐ Yes ☐ No
Are any medications or chemicals stored in your house secure? ☐ Yes ☐ No ☐ N/A	**Does your child use a car seat?** ☐ Back Facing ☐ Front Facing ☐ Booster ☐ None
Are any guns stored in your house? ☐ Yes ☐ No **If so, are they secured in a gun safe?** ☐ Yes ☐ No	**What kind of physical activities does your child do?** ☐ Jogging/Walking ☐ Team Sports ☐ Tennis ☐ Biking ☐ Yoga ☐ Other:
What are your child's hobbies and leisure activities?	**Please rate your child's daily energy levels:** ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None
How many hours does your child sleep at night?	**Does your child have trouble falling asleep?**
Does your child sleep through the night?	**Does your child wake feeling rested?**
Was your child breastfed? ☐ Yes ☐ No How long?	**Was your child formula fed?** ☐ Yes ☐ No How long?
At what age were solids introduced?	**Does your child avoid any particular foods?**
Does your child experience any symptoms immediately after eating certain foods, such as belching, bloating, sneezing, or hives?	
Does your child experience any delayed symptoms after eating, certain foods (24 hours+) such as fatigue, muscle aches, or sinus congestion?	
Does your child feel worse after eating or drinking any of the following? ☐ High Fat Foods ☐ High Protein Foods ☐ Carbohydrates ☐ Sugar/Junk Foods	
How often does your child typically have a bowel movement? ☐ More than 3 times a day ☐ 1-3 times a day ☐ 4-6 times a week ☐ 2-3 times a week ☐ 1 or less times a week	
How would you describe the bowel movements? ☐ Soft and well formed ☐ Often floats ☐ Difficult to pass ☐ Diarrhea ☐ Thin, long and narrow ☐ Small and hard ☐ Loose but not watery ☐ Alternating loose/hard ☐ Greasy or shiny ☐ Brown ☐ Yellow or light brown ☐ Color Varies ☐ Dark or black ☐ Greenish	
Does your child experience gas? ☐ Often ☐ Occasionally ☐ Rarely	**Is your child on a special diet?**
How often has your child taken antibiotics?: ☐ less than 5 times ☐ more than 5 times	**How often has your child taken oral steroids?:** ☐ less than 5 times ☐ more than 5 times
Have you noticed any of the following changes to your child's hair? ☐ Dryness ☐ Brittle ☐ Change in texture ☐ Thinning ☐ Hair loss ☐ Other_____	
Have you noticed any of the following changes to your child's skin? ☐ Dryness ☐ Redness ☐ Rash ☐ Oily ☐ Acne/Breakouts ☐ Other_____	