OpenMind Medicine
Krista Tricarico, ND

Patient Information

Name ___________________________ Age ______ Date of Birth __________

Household Members Include ____

Parent/Guardian Information

Name(s) ____

Address ______________________ City _________ State _____ Zip _______

Phone(s) _______________________ Email address _____________________

Who may I thank for your referral? ____________________________________

Current Health Care Team

Child's Primary Care Doctor ______________________ Phone_____________

Other Provider _________________________________ Phone _____________

Child's Current Health

What is your main reason for coming in today?

____

____

What are your top health concerns for this child in order of importance?

____

____

What types of physical or mental health treatment has the child received lately?

____

____

Current medications (including supplements, vitamins, and herbs):

____

____

Allergies (drugs, chemicals, foods, environmental):

____

____

Past operations / serious illnesses:

____

____

Medical History

__ Chicken pox	__ Measles	__ Mumps	__ Rubella
__ Scarlet fever	__ Strep throat	__ Pneumonia	__ Colic
__ Croup	__ Bronchitis	__ Tonsillitis	__ Ear infection
__ Allergies	__ Asthma		

Immunization History (number received / number suggested)

Diptheria: / 4	Pertussis: / 4	Tetanus: /4	Polio: /4
Hepatitis B: / 3	Measles: / 2	Mumps: / 2	Rubella: /2
H. Flu: / 3			

Family Medical History

Please note the diseases each family member has or had if known.

Mother

____

Father

____

Maternal Grandmother

____

Maternal Grandfather

____

Paternal Grandmother

____

Paternal Grandfather

____

Siblings

____

Typical Diet
Breakfast
____
Lunch
____
Dinner
____
Snacks
____

Please describe your child's energy level. __________________________

____

Any difficulties with sleep? _______________________________________

____

Do you have behavior concerns? __________________________________

____

Please describe her/his general temperament. ________________________

____

Does your child appear to be growing well? _________________________

Are there any concerns of developmental delay? _____________________

Are there any concerns of learning disabilities? ______________________

____

Does your child enjoy school? ______________________________________

Does your child interact well with other children? ____________________

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