Patient Information

Sellwood Family Medicine LLC

1567 SE Tacoma Street, Portland, OR, 97202 ☎ 503.233.8113

Today's date: _____/_____/_____

PATIENT'S INFORMATION

Name:_____ Date of Birth _____
Last First M.I.

Home Address:_____
Street Address Apt # City State Zip Code

Email (for our use only) _____ Home Phone: _____ Cell phone:_____

PARENT'S EMPLOYER INFORMATION

Employer's Name: _____

Employer's Address: _____

_____

Employment Status (circle):
not employed / full time / part time / retired

Work phone: Driver's

Were you referred to this clinic? yes / no

If so, by whom? _____

If not, how did you hear about us?

_____

In case of an emergency, whom should we contact? Name:

_____

Phone: _____

Relationship: _____

INSURANCE INFORMATION

Insurance Company Name:_____

Insurance Company Address: _____
Street Address City State Zip Code

Policy Holder Name: _____ Relationship to you: self/spouse/child/other

Policy Holder employer: _____ Policy Holder's date of birth: ____/_____/_____

Secondary Insurance Company Name:_____

Insurance Company Address: _____
Street Address City State Zip Code

Policy Holder Name:_____Relationship to you: self/spouse/child/other

Policy Holder employer: _____ Policy Holder's date of birth: _____/_____/_____

Your marital status: _____ Your Student status: non student / full time / part time

FINANCIAL POLICY

We are committed to providing you with the best possible medical care at the lowest possible cost. Prompt payment allows us to control costs, which ultimately keeps our fees to a minimum. The following is a statement of our financial policy that we require you to read and sign prior to your first treatment:

Payment in full is due at the time of service. We accept credit cards, cash and checks. Our practice participates with some insurance carriers and as a courtesy to patients, we will file claims directly with the respective insurance company. At the time of service, we require payment for any non-covered services, standard co-pay, and coinsurance. Patients whose co-insurance is based upon a percentage of the charge should pay their designated percentage of the bill at the time of service. If you have a deductible that has not been met, your insurance carrier will apply fees for today's services to that deductible. We ask that you pay upfront for that deductable.

Patients are responsible for obtaining the necessary referral form, if their insurance company requires one. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowance for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Unless we are notified at least 24 hours in advance, our policy is to charge for missed appointments.

Our practice believes that a good doctor-patient relationship is based upon effective communications. If you have any questions, please feel welcome to contact us at 503-233-8113.

By signing below I agree that I have read and understand this policy.

SIGNATURE: _____ **DATE:** _____

Sellwood Family Medicine, LLC

1567 SE Tacoma St. Portland, OR 97202
Tel:(503) 233-8113 Fax: (503) 239-8937

Consent to Treatment of A Minor

I, being the parent/ guardian of _____, a minor, the age of _____ do hereby consent, authorize and request Dr. Leigh Ann Chapman or Dr. Patrick Chapman to administer such treatment deemed advisable, necessary or requested on the above minor.

Signed _____ Date _____
(Parent or Guardian)

Consent to Participate in Research

Dr. Chapman is currently involved in data collection and clinical research regarding the treatment of children with Autism, ADHD, Asperger syndrome and other pediatric developmental disorders. If you choose to participate, your child's information will be used anonymously to contribute to the body of research and information available to improve treatment of children with developmental disorders. Information utilized will include, but is not limited to age, symptoms, diagnosis, treatment response, lab values and medications being used.

Several research studies are already underway regarding Vitamin D, Glutathione and Oxytocin. If you would like to enroll your child, Dr. Chapman would be happy to discuss the projects with you.

☐ Yes, I agree to allow my child's information to be used anonymously for research

☐ Yes, I would like to participate in the following research studies:

(Please initial beside the topic that applies to your child)

Glutathione replacement

Vitamin D

Oxytocin

Case series involving my child's specific treatment plan

☐ No, I would not like my child's information to be used anonymously for research

☐ No I would not like to participate in any research studies

Patient Health History

Mother's Name:_____ Fathers Name:_____

Siblings (and ages):

What are your main health concerns and expectations for this visit?

Who are your main caretakers?

Who is your Primary Care Physician (PCP) and when was your last visit? Why?

Do you have any pre-existing medical conditions or diagnoses?

Do you have any allergies or sensitivities to drugs, foods, environmentals or otherwise?

Were you vaccinated up to schedule? Do you need any information about vaccination?

What are the major stressors in your life?

When and where have you traveled outside of the country?

Are you taking any medications?

Medication	Dose	Frequency	Reason/ condition

Are you taking any supplements, vitamins or herbs?

Supplement	Dose	Frequency	Reason/ condition

Diet/ Nutrition:

Were you breast fed? Yes/ No If so, for how long? _____

If formula fed, what kind (soy, dairy, nutramagen, etc.) _____

What is your diet like? (Typical breakfast, lunch dinner and snack) Food Cravings?

What kind of pets do you have? (indoor and outdoor)

Do you have a faith/ spirituality and how important is it in your family's life?

What are your favorite toys/ hobbies/ interests?

Are there other things I should know about you?

Autism/ Aspergers/ ADHD/ Neurological Development Intake

Perinatal and Birth History: **Please mark Y or N and elaborate if needed**

Very active before birth?	
Hospital birth or home?	
Needed newborn special care?	
Appeared healthy	
Easily consoled during first month?	
Antibiotics in the first month?	
Any complication during the first month?	

Birth weight (lbs)_____ Apgar Score at 1 minute _____ At 5 minutes?_____

Early Childhood illnesses:

First round of antibiotics at _____ months.

First illness at _____ months.

Number of ear infections in the first 2 years?_____

Number of other infections in the first 2 years?_____

How many rounds of antibiotics in the first 2 years?_____

Any prophylactic antibiotics in the first 2 years?_____ Why?_____

Developmental History:

Are there developmental problems? Yes/ No

What age did the problems appear? _____

Is this impression shared by others caring for your child? (doctors, family, caretakers?)

Is there a strong indication as to when the problems started? Pursuant to what?

Has there been any regression of skills? Yes/ No

Has there been any ***lost language*** skills? When?

When, if any, was there ***lost eye contact***? When?

Please indicate the approximate age in months for the following milestones:

Sitting up	
Crawling	
Pulled to stand	
Potty trained	
Walked alone	
Dry at night	
First words	
Spoke clearly	
Ate solid food	

Please mark Y if any symptoms apply currently, N if never had the symptom or P if the symptom was in the past. Comment if necessary.

SYMPTOM	Y, N or P	COMMENT
Enlarged lymph nodes- neck		
Enlarged nodes elsewhere		
Lymph nodes tender		
Overweight		
Underweight		
Pupils unusually large		
Pupils unusually small		
Dark circles under eyes		
Unusually long eyelashes		
Webbed toes		
SENSORY SYMPTOMS		
Unusually fearful		
Unaware of danger		
Unaware of others' feelings		
Very sensitive to pain		
Insensitive to pain		
Bothered by certain sounds		
Ear pain		
Ear ringing		
Hearing acute		
Hearing loss		
Sensitive to loud noise		
Covers ears		
Excessive ear wax		
Likes head pressed or rubbed		
Intensely aware of odors		
Sniffs things		
Sensory problems with food		
Hates wearing shoes		
Blinking		
Bothered by bright light		
Fails to blink at light		
Likes flickering lights		
Poor vision		
Strabismus (crossed eyes)		
Adopts complicated rituals		
Collects particular things		
Draws only certain things		
Fixated on one topic. (what?)		
Lines objects up precisely		

Repeats phrases/ sentences		
Repetitive play		
BEHAVIOR		
Upset if things change		
Aloof, indifferent, remote		
Bites and chews fingers/hands		
Constant movement		
Curious, gets into things		
Destructive		
Extremely cautious		
Head banging		
Hyperactive		
Melt downs		
Poor focus/ attention		
Silly		
Toe walking		
Uninterested in pet		
Mean to pets		
Unusual play		
Teases others		
Tries to control others		
Unpredictable		
Poor eye contact		
Finger flicking		
Flaps hands		
Jumps when pleased		
Licking		
Likes spinning objects		
Rhythmic rocking		
Sits and stares		
Tooth tapping		
Looks out of sides of eyes		
Lacks initiative		
Anxiety		
Inconsolable crying		
Phobias? What?		
Mood swings		
COMMUNICATION		
Does not ask questions		
Poor expressive language		
Points to objects, but can't name		
Talks to self		
SLEEP-more or less than normal?		
Awakes at night		

Difficulty falling asleep		
Nightmares		
Sleepwalking		
DIGESTION/ FOOD		
Pica (eats indigestible things)		
Always thirsty		
Behavior worse with food		
Binge eating		
Bread/ Carb craving		
Craving for juice		
Craving for salt		
Diet soda craving		
Poor appetite		
Abdominal bloating/ pain		
Burping		
Constipation		
Diarrhea		
Passing gas		
Foul smelling gas		
Rectal fissure, bleeding		
Geographic tongue (map like)		
Cracks in corners of lips		
Gums bleed		
Cold sores		
Thrush		
Anal itching, redness		
Intestinal parasites		
Acid reflux		
Nausea		
Sore throat		
Stools foul smelling		
Mucous in stool		
Undigested food in stool		
Grinding teeth		
Vomiting		
Headaches		
RESPIRATORY		
Bad odor in nose		
Breath holding		
Bronchitis		
Congestion with seasons		
Cough		
Pneumonia		
Post nasal drip		

Sighing		
Wheezing/ Asthma		
Yawning		
Sinus problems		
SKIN		
Acne		
Athletes foot		
Blotchy skin		
Frequent bug bites		
Cellulite		
Chicken skin		
Birth marks		
Diaper rash		
Ears get red		
Easy bruising		
Eczema		
Conjunctivitis		
Eye crusting		
Flushing		
Lid margin reddness		
Odd body odor/ Sweat odor		
Oily skin		
Psoriasis		
Vitiligo		
Itching frequent? Where??? (Anus, arms, ears, eyes, feet, nose, penis, scalp, vagina???)		
Dry hair		
Dry skin		
Feet cracking		
Foot odor – stinky?		
Nail fungus		
Sweats in sleep/ Nightsweats		
Thick nails		
White spots on nails		
MUSCULAR/ SKELETAL		
Joint pain		
Muscle cramps		
Muscle pain		
Muscle tone tense		
Muscle tone limp		
Muscles twitch		
Tics		
Numbness/ tingling		

REPRODUCTIVE		
Girls: Age of 1st menstruation		
Boys: Undescended testicle		
Early breast development		
Early pubic hair		
URINARY		
Bedwetting after age 4		
Odd urinary odor		
Urinary infections		
Urinary urgency		
Urinary hesitancy		
GENERAL		
Physically Awkward		
Seizures		
Stiffens body when held		
Unusual sound of cry		
Abnormal fatigue		
Moaning		
Heart murmur		
Mitral Valve Prolapse		
Fast heart rate		
Cheek/ ear pink or cold		
Cold all over		
Cold hands and feet		
Cold intolerance		
Hands/ feet sweaty		
Tip of nose pink or cold		

Biological Mother's Pregnancy History

Age of mother at child's birth_____ Age of father at child's birth_____
Mother's # of pregnancies_____ Births_____ Miscarriages____ Abortions____

Please mark Yes or No for the following situations occurring during your pregnancy.

Symptom or situation	Y or N?	Comment if needed
Difficulty conceiving (> 6 mos.)		
Infertility drugs used		
In vitro fertilization		
Drink alcohol		
Smoke cigarettes		
Take progesterone		
Take prenatal vitamins		
Take antibiotics		
Take other drugs/ medications		
Excessive nausea or vomiting		
Have a viral infection		
Have a yeast infection		
Have dental fillings put in		
Have dental fillings removed		
Have bleeding (which months)		
Group B strep infection		
C- section		
Pitocin during labor		
Have an X- ray		
Have Rhogam? How many?		
High blood pressure		
Chemical exposure		
Have house exterminated		
Have house painted		
Total weight gain in pregnancy		