



## New Patient Child Intake Form (ages 0-17)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Legal sex: ☐ Male ☐ Female SSN: \_\_\_\_\_

Gender: ☐ Girl ☐ Boy ☐ Trans-Girl ☐ Trans-Boy ☐ Non-binary ☐ Genderqueer ☐ Agender  
☐ Not listed: \_\_\_\_\_

Sex Assigned at Birth: ☐ Male ☐ Female

### General

1. Where was the child born? \_\_\_\_\_
2. What was their birth weight? \_\_\_\_\_
3. Were there any problems during the pregnancy? ☐ Yes ☐ No
4. Was the child born at term (on-time)? ☐ Yes ☐ No
5. When was the last time the child was seen by a primary care provider? \_\_\_\_\_

Who did they see? \_\_\_\_\_

6. Do you think the child is up to date on immunizations? ☐ Yes ☐ No
7. Has the child ever been hospitalized? ☐ Yes ☐ No

### Allergies

8. Has the child ever had any allergic reaction (bad effect) to a medicine or shot? ☐ No ☐ Yes

Please write the name of the medicine or shot and the effect: \_\_\_\_\_

9. Does the child get a significant allergic reaction (bad effect) from anything else? ☐ No, they have no allergies.  
☐ Yes, please list: \_\_\_\_\_

### Medicines

10. Please list any prescription medications or supplements that the child has been prescribed and/or are currently taking:  
☐ No, they do not take any prescription medications.  
☐ I brought my pill bottles or a list **OR**

List your medications below:

Pharmacy: \_\_\_\_\_

Medicine or Supplement name	Strength or amount	How many pills do you take?			
EXAMPLE: <i>Furosemide</i>	<i>20mg</i>	<i>2</i> morning	<i>1</i> noon	<i>1</i> dinner	<i>2</i> bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed
		morning	noon	dinner	bed

### Surgical History

11. Has the child ever had surgery? ☐ No, they have never had surgery ☐ Yes. Please list each surgery below.

Surgery	Date

### Medical History

12. Has the child **ever** had any of the following health problems? *Check all that apply.*

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                               | <input type="checkbox"/> Kidney stones                                    |
| <input type="checkbox"/> Allergies                              | <input type="checkbox"/> Meningitis                                       |
| <input type="checkbox"/> Anxiety                                | <input type="checkbox"/> Otitis media (recurrent ear infections)          |
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Pneumonia  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Prematurity (born too early)                     |
| <input type="checkbox"/> Cancer (type: _____)                   | <input type="checkbox"/> Scoliosis (curving of the backbone)              |
| <input type="checkbox"/> Diabetes (high blood sugar)            | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Eating disorder                        | <input type="checkbox"/> Sickle cell (disorder affecting red blood cells) |
| <input type="checkbox"/> Eczema (skin problem)                  | <input type="checkbox"/> Strep throat (recurring throat infection)        |
| <input type="checkbox"/> Headaches                              | <input type="checkbox"/> Thyroid disease                                  |
| <input type="checkbox"/> Hearing loss                           | <input type="checkbox"/> Tuberculosis (TB, lung disease)                  |
| <input type="checkbox"/> Heart murmur (extra noise heart makes) | <input type="checkbox"/> Urinary infections                               |
| <input type="checkbox"/> Immune deficiency                      | <input type="checkbox"/> Varicella (chicken pox)                          |
| <input type="checkbox"/> Inflammatory bowel disease             | <input type="checkbox"/> Vision problem (problems seeing)                 |
| <input type="checkbox"/> Jaundice (skin and eyes turn yellow)   | <input type="checkbox"/> Other: _____                                     |

### Family History

13. Have any of the child's family members ever had any of the following health problems? *Check all that apply.*

Name		Alive?	No known history	Arthritis	Asthma	Birth Defects	Cancer	Depression	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Obesity	Stroke	Substance Abuse	Thyroid Disease	Other
Mother																	
Father																	
Sister																	
Sister																	
Brother																	
Brother																	
MGM																	
MGF																	
PGM																	
PGF																	

**Social History**

14. Please answer the following:

	Yes	No
Does anyone in the family smoke?		
Does the child use community resources?		
Is the child in school? Grade: _____		
Are there any pets in the home?		
Recent travel outside of the area?		
Tobacco exposure inside the home?		
Tobacco exposure outside the home?		
Is the child adopted?		
Has there been a divorce or separation?		
Any DHS involvement?		
Is the child in foster care or in a group home?		
Is either parent incarcerated?		
Has the child or another child in the home been incarcerated?		
Firearms in the child's home?		
Who does the child live with?		

**Specialty Services**

15. Is the child currently seeing any other doctors?

Doctor's name: \_\_\_\_\_ Type of doctor: \_\_\_\_\_

When last seen: \_\_\_\_\_ Phone number: \_\_\_\_\_

Doctor's name: \_\_\_\_\_ Type of doctor: \_\_\_\_\_

When last seen: \_\_\_\_\_ Phone number: \_\_\_\_\_

Doctor's name: \_\_\_\_\_ Type of doctor: \_\_\_\_\_

When last seen: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Anything else we should know?**

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# Southwest Family Physicians

— YOUR FAMILY IS OUR FAMILY —

11900 SW Greenburg Rd  
Tigard, OR 97223

Phone: (503) 620-5556  
Fax: (503) 624-0118

## Release of Records - Authorization to Disclose Protected Information

*I do hereby consent and authorize Southwest Family Physicians to release or request copies of my medical records.*

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

REQUEST RECORDS FROM	RELEASE RECORDS TO
Facility name: _____	Facility name: _____
Address: _____ _____	Address: _____ _____
Phone number: _____	Phone number: _____
Fax number: _____	Fax number: _____

### Please select the purpose for your request:

☐ Continuity ☐ Transfer of care ☐ Disability ☐ Insurance ☐ Legal ☐ Other: \_\_\_\_\_

This authorization shall begin immediately and remain in effect for not more than 180 days from today's date unless another date is specified.

Please select the specific information that applies to your request.

- |  |   |
|--|---|
| <input type="checkbox"/> Most recent 5 year history                                  | <input type="checkbox"/> Laboratory/Pathology       |
| <input type="checkbox"/> Clinical chart notes  | <input type="checkbox"/> Diagnostic Imaging Reports |
| <input type="checkbox"/> Prenatal/OB notes   | <input type="checkbox"/> Immunizations              |
| <input type="checkbox"/> Other: _____  |   |
| <input type="checkbox"/> Records related to (specific dates, conditions, etc.) _____ |   |

If the information to be disclosed or requested contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed or requested if I place my initials in the applicable space next to the type of information.

\_\_\_\_\_ HIV/AIDS    \_\_\_\_\_ Genetic testing    \_\_\_\_\_ Mental health    \_\_\_\_\_ Drug/alcohol information

Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care service or reimbursement for services. I understand I may revoke this authorization in writing at any time. The only exception is when information has already been released in response to this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

Patient signature (or authorized individual): \_\_\_\_\_ Date: \_\_\_\_\_

If signed by another person, indicate relationship: \_\_\_\_\_

**PLEASE DO NOT SEND MEDICAL RECORDS BY CD - WE DO NOT ACCEPT THIS FORM OF RECORDS.**



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## Release of Information

Instructions: Fill in the name of any person(s) to allow Southwest Family Physicians to discuss your medical information with them.

I, \_\_\_\_\_, with date of birth, \_\_\_\_\_, give the providers and office staff of Southwest Family Physicians permission to discuss my medical condition with the listed person(s) below. Southwest Family Physicians may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

Please **initial** the information you want disclosed:

\_\_\_\_\_ Information relating to my medical treatment

\_\_\_\_\_ Psychiatric disorders/Mental health

\_\_\_\_\_ Alcohol/Substance abuse

\_\_\_\_\_ Sexually Transmitted Diseases/HIV

\_\_\_\_\_ All other health information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Note: This authorization does NOT allow for the sharing of copies from the patient's health record. If there is an anticipated need for copies of the patient's health record, our standard form must be completed and submitted to the medical records department.

The consent will be considered valid for 2 years or until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's date: \_\_\_\_\_



## Prescription Policy

Since the advent of pharmacy automated prescription refills, our office receives an ever increasing volume of calls and faxes daily for medications refill requests. We cannot safely manage this volume of phone and faxed medication requests and still provide you with the quality of care you deserve.

1. Before you come to your appointment, you should look over your medications, diabetes supplies, inhalers, etc. to determine if you need to request any new prescriptions while you are here at your face to face appointment.
2. We do require office visits on a regular basis for all of our patients taking prescription medication. The interval will vary, depending on the type of medication prescribed, how sick or stable your condition is, and what is agreed upon between you and your provider when you are here. **Please be sure you have enough medication to last until your next scheduled visit.**
3. Please bring all your prescription bottles with you to your appointment or a list including name of medication, dose, how often you take the medication, and the prescribing provider. This is important to make sure we cross-check that you are taking the correct medications and the correct doses. We will continue to take time to carefully review your medication and write enough refills at your office visit. We will also ask you to review the new prescriptions to make sure that they are written correctly.
4. We offer the following options for your in office, face to face prescription refills:
  - We can send most prescriptions electronically to most local pharmacies.
  - We can send prescriptions electronically to a mail-order pharmacy. You need to already have an account set up with the mail-order pharmacy for us to do this.
  - We can provide written prescriptions.
  - Prescriptions for certain narcotics, mental health medications, including those for attention deficit disorder medication must be printed and hand signed, as it is required by law.
5. Please plan your prescription needs in advance: prescription refill requests should not be coming to us over the phone and fax, unless there is some urgent exception. All refills will be reviewed, discussed, and refilled face to face. In the event of a rare exception, refills may take up to **2 business days**. If it is a prescription that must be hand signed and picked up at the office it may take up to **4 business days or longer**, should your provider be out of the office.
6. If you call to request a refill, but are overdue for a follow-up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in just enough medication to a local pharmacy to last until we are able to schedule an office visit. **It is your responsibility to schedule an appointment before you run out of medication.**



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7. We understand that there might be a situation when you do have to call us for a prescription. Check the list below and see what you can do to avoid incurring a prescription refill fees at the pharmacy.
- **Are you changing to a new local pharmacy?** You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions.
  - **Are you going on an extended vacation and need to use an out-of-town pharmacy?** You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to have your prescription transferred. When you return home, you have to reverse the process.
  - **Are you changing to a new mail order pharmacy?** Some pharmacies will transfer prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

Thank you for choosing Southwest Family Physicians as your provider. We look forward to working with you to assure safe and high quality medical care.

*By signing below, I hereby confirm that I have thoroughly read, understand and consent to the terms outlined in this document.*

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's date: \_\_\_\_\_



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

## Social Determinants of Health

### Living Situation

**1. What is your living situation today?**



- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

**2. Think about the place you live. Do you have problems with any of the following?**



CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

### Food

**3. Within the past 12 months, you worried that your food would run out before you got money to buy more.**



- ☐ Often true      ☐ Sometimes true      ☐ Never true

**4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**



- ☐ Often true      ☐ Sometimes true      ☐ Never true

### Transportation

**5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**



- ☐ Yes      ☐ No