Frontier Health and Wellness

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 Birth: _____ Form Completed By: _____

Please provide a list of your child's previous (last 5 years) and current medical and mental health providers:

Provider Type	Provider Name	Clinic/Hospital Name	Phone Number	Location (City/State)
Pediatrician				
Previous Pediatrician(s) (last 5 years)				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.)				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.)				
Therapy				
Psychiatry				
Neuropsych Testing				
Other:				
Other:				

Please list all your child's medications they are currently taking:

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all of your child's previously taken psychiatric medication:

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all supplements/over the counter medications your child is currently taking:

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list any of your child's known allergies as well as the reaction that occurs:

Allergen	Severity of Reaction			Type of Reaction
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	
	☐ Mild	☐ Moderate	☐ Severe	

Current or previous substance use:

Substance	Frequency of Use					
Caffeine	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Tobacco/Vaping	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Alcohol	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Opioids/ Prescription Drugs	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Marijuana	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Hallucinogens	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Amphetamines	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never
Other:	☐ Daily	☐ Weekly	☐ 1-2x month	☐ Occasionally/Socially	☐ Tried it once or twice	☐ Never

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Patient History Questionnaire (Adult)

Family Medical History:

Medical Condition	Patient or Family History	Please list the Family Member(s) affected
Anemia	☐ Patient ☐ Family History	
Asthma/Respiratory Concerns	☐ Patient ☐ Family History	
Cancer	☐ Patient ☐ Family History	
Chronic Fatigue	☐ Patient ☐ Family History	
Concussion(s) or TBI	☐ Patient ☐ Family History	
Diabetes	☐ Patient ☐ Family History	
Epilepsy/Seizures	☐ Patient ☐ Family History	
Heart Disease/Condition	☐ Patient ☐ Family History	
High Blood Pressure	☐ Patient ☐ Family History	
Insomnia	☐ Patient ☐ Family History	
Stomach/ GI Problems	☐ Patient ☐ Family History	
Stroke	☐ Patient ☐ Family History	
Substance Abuse	☐ Patient ☐ Family History	
Thyroid Disease	☐ Patient ☐ Family History	

Psychiatric history:

Psychiatric Condition	Patient or Family History	Please list the Family Member(s) affected
ADHD	☐ Patient ☐ Family History	
Anger	☐ Patient ☐ Family History	
Anxiety	☐ Patient ☐ Family History	
Bi-Polar Disorder	☐ Patient ☐ Family History	
Depression	☐ Patient ☐ Family History	
Inpatient Psychiatric Care	☐ Patient ☐ Family History	
OCD	☐ Patient ☐ Family History	
PTSD	☐ Patient ☐ Family History	
Schizophrenia	☐ Patient ☐ Family History	
Suicide	☐ Patient ☐ Family History	

Please list any of your child's surgical history or hospitalizations

Surgery/Reason for Hospitalization	Date(s)	Hospital	Doctor/Attending	Location (City, State)

Has your child had any bloodwork completed within the last 6 months (if yes, who ordered the labs to be drawn): ☐ Yes ☐ No

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