

Frontier Health and Wellness, LLC

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 N/A				
Previous Pediatrician(s) (last 5 years) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) N/A				
Therapy N/A				
Psychiatry N/A				
Neuropsych Testing N/A				
Other:				
Other:				

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

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

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

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

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

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: No known allergies

Allergen	Severity of Reaction			Type of Reaction
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	

Current or previous substance use: N/A

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

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Family Medical History: N/A

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

Psychiatric history: N/A

Psychiatric Condition	Patient or Family History		Please list the Family Member(s) affected
ADHD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Anger	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Anxiety	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Bi-Polar Disorder	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Depression	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Inpatient Psychiatric Care	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
OCD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
PTSD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Schizophrenia	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Suicide	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	

Please list any of your child's surgical history or hospitalizations. N/A

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

What school does your child attend? _____ Are they on an IEP? Yes No A 504 Plan? Yes No