Katherine A. Worden, DO, FAAO

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**New Patient Form-Infant/Child**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Parent Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Major Cross Sts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

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

**Family/Pediatric Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring: Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Non-Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Note – Important Information**

Prior to your first visit:

* Please have any relevant imaging reports and/or office notes sent to our office.
* Be aware, we do not bill insurance directly at our office.
* **Be Aware: This is a residential area** 
  + **You will need the Gate Code: #0713**
  + **Please** 
    - **Park in the driveway.**
    - **Please come in -you do not need to ring the bell.**

**Reason(s) for visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications/OTC/Supplements:** (please include dosage and how taken per day or prn [as needed]) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Problems:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries/Procedures (date):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** circle (or mark x as needed)

Father: living/deceased Age: \_\_\_\_\_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: living/deceased Age: \_\_\_\_\_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of sisters: \_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of brothers: \_\_\_\_\_ Health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle (or mark x) if present in any blood relatives (including parents, grandparents, brothers, sisters, children, cousins, aunts, or uncles):

Diabetes Cancer(type)\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure Autoimmune Disease

Heart Disease Lung Disease Tuberculosis Stroke

Epilepsy Psychiatric Illness Migraine Headaches Thyroid Disease

Arthritis Suicide Kidney Disease Liver Disease

Glaucoma Alcohol or Drug Dependency Blood Disease Joint Hypermobility

Co-Vid Infection: yes/no severe: yes/no died: yes/no

Other inherited conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

**Your Support:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition:** Any dietary restrictions/food sensitivities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smokers in the Home: Yes No

Day care? Yes No

Sleep: Does your child sleep well? Yes No

**Osteopathic History:**

**Birth History**: (please circle or mark with X)

Mother’s problems or illness when pregnant with you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery: Vaginal C-section Premature\_\_\_weeks On-time Post dates\_\_Birth Wt:\_\_\_\_\_\_\_\_\_\_

Feeding: Breast Bottle Problems: Feeding Colic Flat spot on head Head only turns one way Constipation Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood History:**

Generally healthy Lots of ear infections Tongue/lip tied Headaches Depression Anxiety

Illnesses/Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Life Stressors: family death divorce Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

(Please circle/x any symptoms/conditions your child have experienced)

**General:** **Head, Eyes, Ears, Nose** **Musculoskeletal:**

Fevers **and Throat:** Joint redness/warmth

Problems with sleep Misshapen/Flattened Head Joint pain/ swelling

Trouble feeding Stiff Neck Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concerns about weight gain Eye problems

Delayed teething **Skin:**

**Cardiovascular:** Difficulty swallowing/Tongue Tie Rashes

Heart problems Hearing problems Cradle cap

Murmur Ear Infections Diaper rash

Turns blue at times Recurrent sore throat Itching

Allergies/Sinus problems

**Respiratory:** **Neurologic:**

Cough or wheezing **Gastrointestinal:** Tremor/shaking

Short of breath Trouble Breast Feeding/latching on Periods of not breathing/Apnea

Transient Tachypnea (TTN) Spits up frequently Arms/Legs Asymmetric

Croup/Bronchiolitis Projectile vomiting Hyperactive

Covid mild/severe Reflux Weakness in arm/leg

Exposure to Tuberculosis Diarrhea/Constipation Poor eye contact Colicky Seizure disorder

**Breast**: Blood in bowel movement

Discharge Abdominal pain/spasm **Neuropsychiatric:** Life Stress problems

**Blood:** **Genitourinary:** Recent family upsetting event:

Jaundice/yellow skin Bladder infections/UTIs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bruise easily Kidney problems Developmentally behind

Swollen glands Sores or pain in genitals **Endocrine:**

Anemia/Polycythemia Discharges Fatigue, excess thirst, urination, Lumps/ Hernia Diabetes, thyroid problems

Growth or weight concerns

Any other Symptoms not listed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR OSTEOPATHIC MANIPULATIVE MEDICINE:**

**I understand that Dr. Worden is a specialist in Osteopathic Manipulative Medicine (OMM) which includes hands-on medical treatment called Osteopathic Manipulative Treatment (OMT) for improved health and relief of pain and dysfunction. Research has shown these techniques to be safe and effective for many common conditions. The most common side effect is temporary aching or soreness from the technique releasing toxins that must be cleared by your body that may last for 1-3 days. This clearance is enhanced by drinking more water and resting your body. If it lasts more that 3 days or is severe, please contact Dr. Worden. Young children may commonly sleep quite soundly or run a fever the night following the treatment as the nervous system resets.**

**Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that Dr. Worden is also a valued professor of OMM. I agree to have occasional advanced medical students or residents present and participating in my treatment when appropriate per Dr. Worden.**

**Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**