Kate's Corner Osteopathic Care PLC

Katherine A. Worden, DO, FAAO
6615 W Misty Willow Ln, Glendale AZ 85310
Ph: 480-564-2905 Fax: 480-564-2906 www.katescornerosteopathic.com

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.**

Kate's Corner Osteopathic Care PLC

Reason(s) for visit: _____
_____
_____

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_____

Kate's Corner Osteopathic Care PLC

Review of Systems

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

General:
Fevers
Problems with sleep
Trouble feeding
Concerns about weight gain

Cardiovascular:
Heart problems
Murmur
Turns blue at times

Respiratory:
Cough or wheezing
Short of breath
Transient Tachypnea (TTN)
Croup/Bronchiolitis
Covid mild/severe
Exposure to Tuberculosis

Breast:
Discharge

Blood:
Jaundice/yellow skin
Bruise easily
Swollen glands
Anemia/Polycythemia

Head, Eyes, Ears, Nose and Throat:
Misshapen/Flattened Head
Stiff Neck
Eye problems
Delayed teething
Difficulty swallowing/Tongue Tie
Hearing problems
Ear Infections
Recurrent sore throat
Allergies/Sinus problems

Gastrointestinal:
Trouble Breast Feeding/latching on
Spits up frequently
Projectile vomiting
Reflux
Diarrhea/Constipation
Colicky
Blood in bowel movement
Abdominal pain/spasm

Genitourinary:
Bladder infections/UTIs
Kidney problems
Sores or pain in genitals
Discharges
Lumps/ Hernia

Musculoskeletal:
Joint redness/warmth
Joint pain/ swelling
Injury _____

Skin:
Rashes
Cradle cap
Diaper rash
Itching

Neurologic:
Tremor/shaking
Periods of not breathing/Apnea
Arms/Legs Asymmetric
Hyperactive
Weakness in arm/leg
Poor eye contact
Seizure disorder

Neuropsychiatric:
Life Stress problems
Recent family upsetting event:
_____
Developmentally behind

Endocrine:
Fatigue, excess thirst, urination,
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**_____