

Pediatric Intake Form

Today's Date _____

Child's Name _____ Parent/Guardian Name(s) _____

Age _____ Date of Birth _____ Gender: Male () Female () **SSN** _____

Address _____ City, State, Zip _____

Phone (____) _____ E-Mail _____

Insurance Company _____ Primary Care Physician _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

HEALTH CONCERNS: (in order of importance)

1. _____
2. _____
3. _____

MEDICAL HISTORY (please check all that apply to your child):

- () Allergies (food, medication, environmental) _____
- () Surgery For what? _____ When? _____
- () Hospitalization For what? _____ When? _____
- () Trauma (i.e. accidents, falls, fractured bones, sprains, etc) Explain _____

Please mark either current (C) or past (P) to all that apply:

- | | | | |
|-----------------------------------|--------------------------|------------------|----------------------------|
| Conjunctivitis/Eye Infections () | Eczema/Hives/Rashes () | Anemia () | Yeast Infection/Thrush () |
| Chicken Pox () | Measles () | Mumps () | Rubella () |
| Mononucleosis () | Ear Infections () | Sinusitis () | Chronic Runny Nose () |
| Frequent Colds () | Asthma () | Pneumonia () | Allergies/Hay Fever () |
| Strep Throat/Tonsillitis () | Chronic Sore Throats () | Constipation () | Colic/Gas/Cramping () |
| Frequent Diarrhea () | Gastric Reflux () | Headaches () | Seizures () |
| Bed Wetting () | Heart Problems () | Depression () | Anxiety () |
| ADD/ADHD () | | | |

FAMILY HISTORY: (Please indicate which relative, if any, has had the following):

- () Allergies _____ () Diabetes _____
- () Asthma _____ () Kidney disease _____
- () Cancer _____ () Heart disease _____
- () Depression _____ () ADD/ADHD _____
- () Other mental illness _____ () Autoimmune disease _____
- () Don't know family medical history

MEDICATIONS: (past and current, include supplements): _____

DIET: Does your child have any food sensitivities/intolerances/dietary restrictions? _____

IMMUNIZATION HISTORY: (please indicate those your child has received and any reactions):

- | | | |
|--|---|--|
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> Td, Tdap | <input type="checkbox"/> MMR (measles, mumps, rubella) |
| <input type="checkbox"/> Haemophilus Influenza B (Hib) | <input type="checkbox"/> Flu | <input type="checkbox"/> Pneumococcal (PCV, PPV) |
| <input type="checkbox"/> Inactivated Polio (IPV) | <input type="checkbox"/> Hepatitis A (HepA) | <input type="checkbox"/> Hepatitis B (HepB) |
| <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Rotavirus | <input type="checkbox"/> Varicella (chicken pox) |
| <input type="checkbox"/> Human Papillomavirus (HPV) | | |

PRENATAL HISTORY:

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, bleeding, toxemia, hospitalizations, medications taken)? Please explain _____

How was the labor and delivery? Were there any interventions (i.e. forceps, vacuum, C- section)? _____

Was your child born: Pre-term Term Post-Term

NEONATAL/INFANT HISTORY:

Child's weight at birth _____ Child's length at birth _____

How were your child's APGAR scores at birth, if known? _____

Was your child breastfed? _____ If Yes, for how long? _____

If No, what formula was your child given? _____

Was your child healthy during the neonatal period? _____ If No, please explain _____

At what age was solid food introduced? _____

SOCIAL HISTORY:

Does your child attend daycare or school? Yes No If Yes, what grade/level are they in? _____

How is your child's social and academic performance (both in school and at home)? _____

Is your child involved in any extra-curricular activities, sports, hobbies? Yes No Please explain:

What does your child enjoy doing on their spare time? _____

Does your child get exercise? Yes No How often/What type? _____

How much sleep does your child get, on average? _____

INFORMED CONSENT and Request for Naturopathic Medicine

I understand and agree that:

- The Naturopathic Physicians at the offices of East Valley Naturopathic Doctors are independent medical practices
- East Valley Naturopathic Doctors assumes no liability arising from treatments administered by such independent Naturopathic Physicians
- Any claims for injuries from treatments administered by such independent Naturopathic Physicians must be brought solely against the independent Naturopathic Physician(s) providing the treatment that caused the injury and not against East Valley Naturopathic Doctors

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, endometrial biopsies, diagnostic imaging, laboratory evaluation of blood, urine, and stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intramuscular vitamin injections)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures, suppositories, which may contain alcohol, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand and I am informed that in the practice of Naturopathic Medicine and Traditional Chinese Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- **Potential risks:** pain, discomfort, minor bruising from Acupuncture; allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- **Potential benefits:** restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- **Notice to pregnant women:** all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I, _____ acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

PATIENT'S NAME (signature)

DATE

PATIENT'S NAME (print or type name)

Financial Policy of East Valley Naturopathic Doctors

Payment Policy

Payment for services are due at the time services are rendered, including for products and labs not specifically covered by insurance.

Insurance Reimbursement Policy

Naturopathic Physicians may be covered by some PPO plans as out-of-network physicians. For your information Medicare does not cover Naturopathic Medicine. As a service to our patients, East Valley Naturopathic Doctors will submit billing claims for reimbursement from the following companies:

Blue Cross/Blue Shield	Humana
Aetna	United Health Care
Great Western	Life Wise
Cigna	HealthNet
Arizona Foundation	And Many Others

Submission of a claim for reimbursement on your own, a superbill providing a summary of the services rendered, diagnoses and charges applied, will be provided for you to send to your insurance company.

Returned Checks

For checks returned as unpaid by your bank, you will be charged a \$25 returned check fee.

Missed Appointments

Please provide at least **24 hours notice** of cancellation as a courtesy. A charge of \$45 will be applied for failure to notify East Valley Naturopathic Doctors of a cancellation prior to the scheduled appointment time.

By signing below I am stating that I have read and understand the Financial Policy of East Valley Naturopathic Doctors.

PATIENT'S NAME (signature)

DATE

PATIENT'S NAME (print or type name)