

Young Naturopathic Center for Wellness

PEDIATRIC HEALTH INTAKE FORM

If your child has started or has gone through puberty, please complete the appropriate adult intake form.

PATIENT INFORMATION

Name:		Date:
Date of Birth:	Age:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
Year in School:	Patient School:	
Parents' Names and Occupations:		
Address:		
City, State, Zip:		
Phone 1: May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone 2: May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email: May we email you information about our office? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact (name and phone): Relationship to patient:		
Who is your child's current Pediatrician? What is the name and number of their clinic?		
Please list other health care professionals from whom your child receives care (Name, specialty, phone):		
When was your child last seen by a medical professional and for what reason? When was your child's last wellness check/physical exam?		
How did you find our office?		
WHAT ARE YOUR CURRENT HEALTH CONCERNS FOR YOUR CHILD? PLEASE LIST IN ORDER OF IMPORTANCE.		
1.	4.	
2.	5.	
3.	6.	
PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE INTERESTED IN:		
Wellness Screening	Food Allergy Testing	Heavy Metal Testing
Nutritional Testing	Digestive Analysis	Anxiety or Mental Health
Testing for Depression	Complete Cardiovascular Panel	Detoxification Diet

PREGNANCY HISTORY

Was your child adopted? <input type="checkbox"/> No <input type="checkbox"/> Yes, at what age and what country of origin?	
Length of this pregnancy (weeks):	Prenatal care began at (months):
Were there any of the following illnesses or problems during pregnancy? <input type="checkbox"/> Rubella (measles) <input type="checkbox"/> Accident/Injury <input type="checkbox"/> Bleeding <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Swelling <input type="checkbox"/> Sugar in urine (Diabetes) <input type="checkbox"/> Excessive weight gain <input type="checkbox"/> Other infections	
Explanation if yes to any of the above:	
Medicines or supplements used during pregnancy:	
Smoking while pregnant: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	Alcohol while pregnant: <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy

BIRTH INFORMATION

How long was labor (hours)?	
Was labor induced?	
At delivery (check all that apply): <input type="checkbox"/> Breech <input type="checkbox"/> Cesarean section <input type="checkbox"/> VBAC <input type="checkbox"/> Breathed and cried immediately <input type="checkbox"/> Resuscitated <input type="checkbox"/> In Oxygen <input type="checkbox"/> Other:	
Did baby require: <input type="checkbox"/> Special nursery <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Antibiotics <input type="checkbox"/> Light therapy	
Did baby have: <input type="checkbox"/> Breathing problems <input type="checkbox"/> Jaundice <input type="checkbox"/> Other:	
Weight at birth:	Length:
Apgar score:	
Discharge weight:	Length of hospital stay:
Describe any problems with birth or first days of life:	
Did baby receive: <input type="checkbox"/> Vitamin K <input type="checkbox"/> Hep B vaccine <input type="checkbox"/> Newborn screening tests	

Check boxes of your child's blood relatives who have had any of the following conditions: <u>circles examples or write in name of disease, if known:</u>	Father	Mother	Father's	Mother's	Siblings
Headaches (migraine, cluster, tension)					
Eye Disease (blindness, tumor, glaucoma)					
Ear Disease (deafness, infections, defects)					
Allergies (eczema, hay fever, sinus, hives)					
Lung (asthma, cystic fibrosis, bronchitis)					
Tuberculosis					
High Blood Pressure					
High Cholesterol					
Heart Attack (age)					
Anemia (Sickle cell, Mediterranean, other)					
Bleeding disorders (hemophilia)					
Stomach or duodenal ulcers					
Liver or gallbladder disease (hepatitis)					
Intestinal disease (colitis, polyps)					
Kidney disease (nephritis, cysts, stones)					
Diabetes					
Thyroid problems (goiter, nodules, hyper/hypo)					
Bone or joint disease (arthritis, osteoporosis)					
Muscle weakness or dystrophy					
Seizure disorder (epilepsy)					
Neurologic					
Learning disability					
Mental retardation (down syndrome, other)					
Mental illness (depression, anxiety, other)					
Alcoholism or drug abuse					
Birth defects (cleft lip, other)					
Obesity					
Cancer: breast, cervix, uterine, ovarian, lung, thyroid, pancreas, kidney, bladder, prostate, testicular, colon, stomach, oral cavity, leukemia, myeloma, lymphoma, skin, brain, or bone					

FAMILY HISTORY

Ethnic origin/Race: Mother:	Father:
Parents: <input type="checkbox"/> Married <input type="checkbox"/> Living together <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Single	
Child lives with: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian, relationship:	
Names and birth dates of living brothers and sisters:	
Other members of household:	
Age of home:	Any pets?
Has any parent, brother or sister died?	Who?
Cause of death, age:	

INFANT NUTRITION

<input type="checkbox"/> Breast milk Duration: weeks/months/years <input type="checkbox"/> Formula Oz per 24 hour period: Brand:	Avg times nursing during 24 hour period:
Feeding problems: <input type="checkbox"/> Vomiting <input type="checkbox"/> Colic <input type="checkbox"/> Diarrhea <input type="checkbox"/> Allergies	Check any that apply: <input type="checkbox"/> Pacifier <input type="checkbox"/> Bottle Age started solid foods:

CHILDHOOD NUTRITION

What has your child eaten over the past day: Breakfast: Lunch: Dinner: Snacks: Fluids	Favorite foods: Proteins: Fruits: Vegetables: Grains: Other:
---	--

SLEEP AND ELIMINATION

Typical bedtime: Wake time: # Wakings/night: # Naps: Length of Naps: Sleep problems:	# Bowel movements/day: Urination/day or wet diapers/day: Elimination problems:
Does your child: <input type="checkbox"/> Share a room <input type="checkbox"/> Share a bed With whom? <input type="checkbox"/> Sleep in a crib <input type="checkbox"/> Sleep in a bunk bed <input type="checkbox"/> Sleep on back <input type="checkbox"/> Sleep on tummy	

MEDICAL HISTORY

Please check the diseases that your child has had and give age: <input type="checkbox"/> Measles, Rubella <input type="checkbox"/> Mumps <input type="checkbox"/> Chickenpox <input type="checkbox"/> Whooping cough <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Anemia <input type="checkbox"/> Heart disease <input type="checkbox"/> Allergies/hay fever <input type="checkbox"/> Eczema <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Strep throat <input type="checkbox"/> Ear infection <input type="checkbox"/> Hepatitis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other illnesses:	
Has your child ever been injured? If yes, age and type of injury:	Any accidental poisoning? If yes, age and substance:
Please list past hospitalizations and surgical procedures (include date and hospital):	
Has your child worn: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Dental braces <input type="checkbox"/> Leg braces <input type="checkbox"/> Corrective shoes <input type="checkbox"/> Orthotics in shoes <input type="checkbox"/> Other braces	
Please list all medications:	Please list all supplements:

Does your have allergies to any of the following:

- Drugs:
- Foods:
- Environment:

Please check if your child has had:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Pink eye | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Frequent stuffy nose |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Frequent stomach aches | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Blood, red or brown urine | <input type="checkbox"/> Joint pains or swelling | <input type="checkbox"/> Inability to get to sleep | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> More than 2 earaches/year | <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> More than 6 colds/year |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Constant or frequent fatigue | <input type="checkbox"/> Frequent diarrhea/constipation | <input type="checkbox"/> Frequent urination or accidents |
| <input type="checkbox"/> Frequent bed wetting after 5yr | <input type="checkbox"/> Excessive weight gain | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Frequent nightmares/sleepwalking |
| <input type="checkbox"/> Signs of sexual development before age 9 | | | |

Other concerns:

CHILD DEVELOPMENT

At what age did your child:

Sit alone: _____ Walk alone: _____
 Feed self: _____ Talk (2-3 word sentences): _____
 Dress self: _____
 Toilet trained: Day: _____ Night: _____

School aged child:

Days of school missed this year: _____

School problems:

Reading/writing Behavior Special needs:

Behavior problems at home: Yes No

Please describe:

IMMUNIZATIONS AND SCREENINGS

Please provide copy of immunization record.

- Immunizations up to date on standard schedule
 - Selective immunizations and/or delayed schedule
- Please explain:

Test	No	Yes	Date(s)	Result
Lead blood test				
TB skin test				
Vision exam				
Hearing test				
Hemoglobin blood test				
Urine test				
Other				

The above information is true to the best of my knowledge.

X _____ Date _____

Signature of Patient or Person Legally Responsible

If you are interested in a **focused initial consultation only** and you would not like to discuss your health history, please complete the following:

I _____ understand the doctors of Young Naturopathic Center for Wellness will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctors will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns

X _____ Date _____

Signature of Patient or Person Legally Responsible

Young Naturopathic Center for Wellness Informed Consent & Office Policies

Our commitment here at the Young Naturopathic Center for Wellness is to serve our patients with professionalism and genuine concern, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving you it may be necessary to share pertinent information with other Health Care Providers or Associates for the purpose of ordering laboratory tests, determination of fees, collection of fees, scheduling of your appointments or to obtain a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released only with your written consent, as provided for by law.

All health and laboratory information will be given at scheduled office or phone appointments. Please be aware when scheduling phone appointments our normal fee's for service apply. If you need your labs and are unable to make an appointment we will fax them to another doctor, but will not send them to you directly unless you have already discussed them with the doctor.

Please be aware that Health and Safety Code section 109250, et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. If you have been diagnosed with cancer, we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit Cards, MasterCard, VISA, cash, and checks are acceptable forms of payment.

Please be advised that if for any reason you cannot keep your scheduled procedure or appointment, we require that you cancel at least 24 hours prior to your appointment. Failure to cancel within that time frame or failure to show for the appointment will result in a \$50 fee. This fee may change without notice.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Renee Young, N.D. and Associates

I have read and understand this form.

Signed: _____

Print Name: _____ Date: _____

Young Naturopathic Center for Wellness Informed Consent to Naturopathic Treatment and Care

I have had an opportunity to discuss the nature and purpose for naturopathic care and its procedures with the Doctor of Naturopathic Medicine named below and / or other office or clinic personnel.

I hereby request and consent to Naturopathic Medicine as an alternative treatment for my health conditions (or for those of the patient named below, for whom I am legally responsible) as performed by the Doctor of Naturopathic Medicine named below and / or other licensed Doctors of Naturopathic Medicine who may now, or in the future, treat me while employed by, working or associated with, serving as back-up for the Doctor of Naturopathic Medicine named below, whether they work at the clinic or office listed below or any other office or clinic. Treatments may include- but are not limited to- herbal medicine, homeopathic medicine, life style and nutritional counseling, naturopathic manual therapy, physical therapy, injection therapy, and hormone replacement.

I have been informed that in the practice of medicine there are some risks to treatment, including -but not limited to- side effects of medication, allergic reactions, anaphylaxis, fractures, disc injuries, strokes, dislocation, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the Doctor's judgment based upon the facts then known, to provide me with any care and procedures considered to be in my best interest during the course of my treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by it I agree to the procedures mentioned above. I indent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:
the

To be completed by patient's representative, if necessary, e.g. if
patient is a minor or physically or legally incapacitate.

Print Patient's Name

Print Name of Patient

Signature of Patient

Print Name of Patients Representative

Date Signed

Signature of Patients Representative
(Include Relationship or Authority of Representative.)

Date Signed

Name of Doctor treating this patient: **Dr. Renee Young or Dr. Jennifer Larsen**