

Willowbend Natural Medicine

PEDIATRIC INTAKE FORM

Patient's Name _____
Patient's Date of Birth ____/____/____ Age: _____ Gender M _____ F _____
Home Street address: _____
City: _____ State: _____ ZIP: _____
Mother's Name _____ Contact phone _____
Father's Name _____ Contact phone _____
Email (both or either parent) _____

Reason for visit _____

Medications	Now	Past	Other Medications:
Antibiotics	_____	_____	_____
Antihistamine	_____	_____	_____
Aspirin	_____	_____	Allergies to medication: List drug and type of reaction:
Decongestant	_____	_____	_____
Ibuprofen	_____	_____	_____
Tylenol	_____	_____	_____

Medical History

Childhood Illnesses: "check" if had disease, mark "V" if had vaccination

_____ Chicken Pox	_____ Scarlet fever	_____ Tonsillitis
_____ Measles	_____ Pneumonia	_____ # of times _____
_____ Mumps	_____ Frequent colds	_____ Ear infections
_____ Rubella	_____ Rheumatic fever	_____ # of times _____

Immunizations

_____ Polio	_____ MMR	_____ HIB	_____ Hepatitis B
_____ DPT	_____ Tetanus	_____ Chickenpox	Other: _____

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech / Language	_____	_____	_____
Vision	_____	_____	_____

Any known allergies:

Injuries / Surgeries / Hospitalizations:

Family History:

_____ Allergies _____ Diabetes _____ Hypoglycemia
_____ Arthritis _____ Heart disease _____ Mental illness
_____ Birth defects _____ Hepatitis _____ Tuberculosis
_____ Cancer _____ Hypertension Other: _____

Mom's Pregnancy History:

Pregnancies by birth mother: _____ Miscarriages _____ # of children _____

Mother's health during pregnancy:

_____ Bleeding _____ Nausea
_____ Diabetes _____ Thyroid problems
_____ Hypertension _____ Physical or emotional trauma
_____ Illness _____ Cigarettes, alcohol, drug consumption

Mother's age at childbirth: _____ Birth Medications (please list): _____

Birth History:

Term: Early: _____ Full: _____ Late: _____ Weight at birth: _____ lbs. _____ oz.

Length of labor: _____ Complications: _____

Has your child had any of the following problems:

_____ Allergies _____ Blue baby _____ Diarrhea _____ Rashes
_____ Birth defects _____ Cerebral palsy _____ Fever _____ Seizures
_____ Birth injuries _____ Colic _____ Jaundice _____ other

Child's sleep patterns (first year): _____

Feeding: Breast fed: _____ how long: _____ Formula: _____ milk / soy / other

Age began: solid foods: _____ Sitting: _____ Crawling: _____ Walking: _____ First words: _____

Symptoms:

Now	Past		Now	Past		Now	Past	
_____	_____	Acne	_____	_____	Eczema	_____	_____	Muscle/bone pain
_____	_____	Anemia	_____	_____	Excessive fatigue	_____	_____	Nervousness
_____	_____	Bleeding gums	_____	_____	Flat feet	_____	_____	Night sweats
_____	_____	Bleeding tendency	_____	_____	Frequent colds	_____	_____	Nightmares
_____	_____	Bloody urine	_____	_____	Frequent headache	_____	_____	Nose bleeds
_____	_____	Body / breath odor	_____	_____	Gas, colic	_____	_____	Runny nose
_____	_____	Burning urination	_____	_____	Hay fever	_____	_____	Sensitive to light
_____	_____	Canker sores	_____	_____	Hair loss	_____	_____	Sleep problems
_____	_____	Chronic rash	_____	_____	Hearing loss	_____	_____	Sore throats
_____	_____	Constipation	_____	_____	Heart murmur	_____	_____	Stomach aches
_____	_____	Cough	_____	_____	Hives	_____	_____	Teeth problems
_____	_____	Cries easily	_____	_____	Jaundice	_____	_____	Unusual fears
_____	_____	Dizzy spells	_____	_____	Joint pains	_____	_____	Vomiting spells
_____	_____	Diarrhea	_____	_____	Lack of appetite	_____	_____	Wheezing
_____	_____	Easy bruising	_____	_____	Motion sickness	Other:	_____	_____

Diet: Please describe your child's typical diet:

Breakfast: _____ Mid AM Snack: _____

Lunch: _____ Mid PM Snack: _____

Dinner: _____ Late PM Snack/dessert: _____

Typical Beverage/fluid intake daily: _____

Urination/day _____ # Bowel Movement/day _____ color: _____ Blood: Y N Mucus: Y N

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use or disclosure of my identifiable health information to Sara Thyr, N.D and Willowbend Natural Medicine for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Sara Thyr, ND may be conditioned upon my consent as by my signature on this document.

My identifiable health information means health information collected from me and created or received by my practitioner, another health care provider, a health plan, my employer. This **identifiable health information** relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Sara Thyr, ND/Willowbend Natural Medicine is not required to agree to the restrictions that I may request. However, if Sara Thyr, ND agrees to a restriction that I request, the restriction is binding upon Sara Thyr, ND and Willowbend Natural Medicine.

I have the right to revoke this consent, in writing, at any time except to the extent that Sara Thyr, ND and Willowbend Natural Medicine has taken action in reliance of this consent.

I understand I have the right to review Willowbend Natural Medicine's Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my *identifiable health information* that will occur in my treatment, payment of my bills or in the performance of health care operations of Willowbend Natural Medicine.

Willowbend Natural Medicine reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current.

Emergency Care:

Our clinic does not administer emergency medical care. In the case of an emergency, please see your family medical/osteopathic physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

We are currently unable to bill insurance.

- Payment is expected at the time of service. We accept personal checks, cash, Mastercard, Visa and Discover.

Cancellation Policy:

This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at the time of services. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship