

# Willowbend Natural Medicine

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## **PEDIATRIC INTAKE FORM**

All contact information is for professional use only and will be held in strict confidence.

Patient's Name	Date of Birth	Age	Gender
Address	City	State	Zip
Parent's Names	Contact Phone #s		
Email (both or either parent)			
Referred by			
Reason for Visit			

### **Medications**

	Now	Past	Name
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antihistamine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Decongestant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Medications, Vitamins, Herbs currently taking

<b>Name</b>	<b>Dose</b>	<b># of times daily</b>	<b>For how long</b>

### **Allergies**

- Drugs Name and reaction \_\_\_\_\_
- Foods Name and reaction \_\_\_\_\_
- Environment (pollen, dander, etc.) Type and reaction \_\_\_\_\_

### MEDICAL HISTORY

#### **Vaccination History**

- |                                      |  |                                      |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Polio (IPV) | <input type="checkbox"/> Chicken pox/Varicella | <input type="checkbox"/> HPV         |
| <input type="checkbox"/> DTaP/Tdap   | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Influenza   |
| <input type="checkbox"/> MMR         | <input type="checkbox"/> Hepatitis B           | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hib         | <input type="checkbox"/> Meningococcus (MCV4)  | <input type="checkbox"/> Other _____ |

#### **Has your child had any of the following tests?**

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

**Hospitalizations, Surgeries, X-rays, other Imaging, and reasons for**

**Year**


**Has your child ever had:**

**Now Past**

- Acne
- Allergies
- Anemia
- Asthma
- Birth defect
- Birth injury
- Bleeding gums
- Bleeding tendency
- Bloody urine
- Blue baby
- Body / breath odor
- Burning urination
- Canker sores
- Cerebral palsy
- Chicken pox
- Constipation
- Cough
- Dizzy spells
- Ear infection #of times\_\_
- Easy bruising
- Eczema
- Excessive fatigue
- Fever

**Now Past**

- Flat feet
- Frequent colds
- Frequent headache
- Gas, colic
- Hair loss
- Hay fever
- Head injury
- Hearing loss
- Heart murmur
- Hives
- Jaundice
- Joint pain
- Lack of appetite
- Measles
- Mercury fillings
- Motion sickness
- Mumps
- Muscle/bone pain
- Nervousness
- Night sweats
- Nightmares
- Nose bleeds
- Pneumonia

**Now Past**

- Rash
  - Reflux
  - Rheumatic fever
  - Rubella
  - Runny nose
  - Scarlet fever
  - Seizure
  - Sensitive skin
  - Sensitive to light
  - Sleep problem
  - Sore throats
  - Stomach ache
  - Strep throat
  - Teeth problems
  - Tonsilitis #of times\_\_\_\_\_
  - Trauma
  - Unusual fears
  - Vaccine reaction
  - Vomiting spells
  - Wheezing
- Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

<b>Condition</b>	<b>Has a relative had this?</b>	<b>Relative</b>	<b>Condition</b>	<b>Has a relative had this?</b>	<b>Relative</b>
Allergies	<input type="checkbox"/>	_____	High cholesterol	<input type="checkbox"/>	_____
Hay fever/hives	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____	Gastrointestinal disease	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	_____
Birth defect	<input type="checkbox"/>	_____	Alzheimer's	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Depression or Anxiety	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____	Addiction	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	_____	Schizophrenia	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	_____	OCD	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	_____	Other/specify	<input type="checkbox"/>	_____

**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 \_\_\_\_\_

**Digestive health:** Constipation Reflux Diarrhea Indigestion Stomach ache # Urination/day\_\_\_\_

# Bowel Movement/day \_\_\_\_ Color: \_\_\_\_\_ Blood: Y / N Mucus: Y / N

MOTHER'S PREGNANCY HISTORY

# of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of terminations \_\_\_\_\_

**Mother's health during pregnancy:**

- |   |  |
|---|--|
| <input type="checkbox"/> Bleeding         | <input type="checkbox"/> Hypertension                          |
| <input type="checkbox"/> Nausea           | <input type="checkbox"/> Physical or emotional trauma          |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Illness                               |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |

Mother's age at childbirth: \_\_\_\_\_ Birth Medications \_\_\_\_\_

**Birth History:**

Term:  Early  Full  Late      Baby's birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Length of labor \_\_\_\_\_ Complications \_\_\_\_\_

**Child's sleep patterns (first year)** \_\_\_\_\_

**Feeding:**      Breast fed Y / N      How long \_\_\_\_\_      Formula \_\_\_\_\_ milk / soy / other

**Age began:**      Solid foods \_\_\_\_\_      Sitting \_\_\_\_\_      Crawling \_\_\_\_\_      Walking \_\_\_\_\_      First words \_\_\_\_\_

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

I consent to the use or disclosure of my identifiable health information by Sara Thyr, N.D. 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 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 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 notice during any office visit.

### 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, American Express & 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.** \_\_\_\_\_ Initial

- 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