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	
Antibiotics	☐	☐	Name _____
Antihistamine	☐	☐	
Aspirin	☐	☐	
Decongestant	☐	☐	
Ibuprofen	☐	☐	
Steroid	☐	☐	
Tylenol	☐	☐	

Medications, Vitamins, Herbs currently taking

Name	***Dose***	***# of times daily***	***For how long***

Allergies

☐ Drugs Name and reaction _____
☐ Foods Name and reaction _____
☐ Environment (pollen, dander, etc.) Type and reaction _____

MEDICAL HISTORY

Vaccination History

☐ Polio (IPV)	☐ Chicken pox/Varicella	☐ HPV
☐ DTaP/Tdap	☐ Hepatitis A	☐ Influenza
☐ MMR	☐ Hepatitis B	☐ Other _____
☐ Hib	☐ Meningococcus (MCV4)	☐ 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		Now	Past		Now	Past	
☐	☐	Acne	☐	☐	Flat feet	☐	☐	Rash
☐	☐	Allergies	☐	☐	Frequent colds	☐	☐	Reflux
☐	☐	Anemia	☐	☐	Frequent headache	☐	☐	Rheumatic fever
☐	☐	Asthma	☐	☐	Gas, colic	☐	☐	Rubella
☐	☐	Birth defect	☐	☐	Hair loss	☐	☐	Runny nose
☐	☐	Birth injury	☐	☐	Hay fever	☐	☐	Scarlet fever
☐	☐	Bleeding gums	☐	☐	Head injury	☐	☐	Seizure
☐	☐	Bleeding tendency	☐	☐	Hearing loss	☐	☐	Sensitive skin
☐	☐	Bloody urine	☐	☐	Heart murmur	☐	☐	Sensitive to light
☐	☐	Blue baby	☐	☐	Hives	☐	☐	Sleep problem
☐	☐	Body / breath odor	☐	☐	Jaundice	☐	☐	Sore throats
☐	☐	Burning urination	☐	☐	Joint pain	☐	☐	Stomach ache
☐	☐	Canker sores	☐	☐	Lack of appetite	☐	☐	Strep throat
☐	☐	Cerebral palsy	☐	☐	Measles	☐	☐	Teeth problems
☐	☐	Chicken pox	☐	☐	Mercury fillings	☐	☐	Tonsilitis #of times_____
☐	☐	Constipation	☐	☐	Motion sickness	☐	☐	Trauma
☐	☐	Cough	☐	☐	Mumps	☐	☐	Unusual fears
☐	☐	Dizzy spells	☐	☐	Muscle/bone pain	☐	☐	Vaccine reaction
☐	☐	Ear infection #of times__	☐	☐	Nervousness	☐	☐	Vomiting spells
☐	☐	Easy bruising	☐	☐	Night sweats	☐	☐	Wheezing
☐	☐	Eczema	☐	☐	Nightmares	Other: _____		
☐	☐	Excessive fatigue	☐	☐	Nose bleeds	_____		
☐	☐	Fever	☐	☐	Pneumonia	_____		

FAMILY HISTORY

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

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:

☐ Bleeding
☐ Nausea
☐ Diabetes
☐ Thyroid problems
☐ Hypertension
☐ Physical or emotional trauma
☐ Illness
☐ 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