Pediatric Patient Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used to remind you of your visits and inform you of our office events & news and will not be distributed for any other use.

First Name ________________________________Last Name____
Address ____
City ________________________Postal Code ________________
Parent/Guardian's Names ____
Telephone (H) ________________________ (W) _______________________ (F) ___________________________
E-mail ____ Cell ____________________________

I have read Welcome to our Office provided with this form. I am aware of the type of treatments offered and I agree to abide by the office policies.

Signature ____ Date ________________________________

Type of school or child care ____
Performance (circle one): Academics: Excellent/Moderate/Weak Concentration: Excellent/Moderate/Weak
Social interaction: Excellent/Moderate/Weak Overall Health: Excellent/Moderate/Weak
Date of Birth __________________ Age ________ Sex M F Parent's Marital Status _______________________
Other Siblings & their ages ____
Blood Type __________ Height _____________ Weight ______________ Ideal Weight __________________
Religion or personal philosophy ____
Name of Medical Doctor __________________________________Telephone ____________________________
Date of last physical ____________________________ Date of last lab tests _____________________________
Has your child been treated by a Naturopathic Doctor? Other health practitioners?
Name ____ Name ____
When? _______________________________________ When? ____
How did you hear about our clinic? ____Yellow Pages ____Internet _____ Friend _______Family
Who can we thank for referring you & your child? ____

Please list (in order of importance) the primary health concerns / reasons for this visit for your child.

1. ____ 4. ____
2. ____ 5. ____
3. ____ 6. ____

Please indicate any **treatments** that you / your child has tried previously to address your child's health issues and **how effective** you found these treatments.

____
____
____
____

Please list all **pharmaceutical medications, herbals, vitamins, and supplements** (& dosages, if known)

Taken now:

____
____
____
____

In the past:

____
____
____
____

Please list any **allergies** your child has and what kind of **reaction** occurs.

____
____
____
____

Please list all **hospitalizations, fractures, or major illnesses** that your child has had. Type of illness, operation / procedure Date Any ongoing concems?

____
____
____
____

How would you rate your child's **energy level**? _______ (from 1-10, 10 being highest) Does s/he wake feeling refreshed? Y___ N___ What time does s/he sleep from and wake up at? ____________________
How many glasses of **water** & of what **kind** does your child drink per day? Please indicate numbers below.
Tap______ Filtered ________ Distilled_________ Reverse Osmosis_________ Spring _________
How many **cups/day** does your child drink of each the following?
Juice _______ Pop ________ Milk _______ Chocolate milk _______ Rice/Soy milk _______
Is your child exposed to cigarette **smoke**? N__Y__ How many years?_____ In the past? Y__ When?______
Does your child **exercise**? N__ Y__ Hours per week ____ Type of exercise ___________________________
Does four child watch **TV**? N__ Y__ # of hours per week _____________

Please check **childhood illnesses** your child has had:
___Measles ____ Rubella ____Whooping Cough ____Rheumatic Fever ____Allergies ____Mumps
___Chicken pox ____Scarlet Fever ___Polio ___ Asthma

Please check any **vaccinations** your child has had. Circle and date the most recent.
___Hep B ___DtaP or DTP ____MMR ____Hib ____Varicella ____Polio

Did s/he have any **adverse reactions** (eg. Rash, flu, extreme upset, vomiting, neurological)?
____

Please circle all of the following **conditions** that are applicable to **your child & his/her family** and note who.

Alcoholism ___________________________________ Gout ____
Allergies_____________________________________ Heart disease ____________________________________
Arthritis _____________________________________ Heart murmurs __________________________________
Asthma _______________________________________ High blood pressure ______________________________
Auto immune___________________________________ Hypothyroid ____________________________________
Cancer _______________________________________ Hyperthyroid ___________________________________
Crohn's or Colitis______________________________ IBS / IBD____
Depression____________________________________ Kidney disease __________________________________
Diabetes______________________________________ Liver disease____________________________________
Eczema_______________________________________ Mental illness___________________________________
Gallbladder____________________________________ Stroke or aneurysm_______________________________
GERD/hiatal hernia______________________________ Ulcers____
Glaucoma / Cataracts____________________________ Other____

******On a separate page, please record everything that your child ate yesterday for breakfast, lunch, dinner, snacks, and beverages in as much detail as possible.**

Cancellation/ Tardiness Policy

The following policy applies to all cancelled & missed appointments with Dr. Tamera Firnbach D.C.:

____ Due to the length of Dr. Firnbach's visits, a cancellation and tardiness policy is in effect as per industry standards. Your time with the doctor is reserved for you in advance and you will be charged for the length of your time spent with her. Please remember this policy and feel free to call to confirm your appointment time and length. We will do our best to remind you of your visit, but it is ultimately your responsibility to arrive on time.

____ Patients must give a minimum 24 hours' notice for cancellations or changes to appointments, or a fee of the appointment cost will be charged. This cancellation fee applies to missed appointments as well.

____ Patients will be invoiced for missed or cancelled appointments and payment is due within one week. Fees will be applied to the credit card provided if not paid within one week of missed appointment.

____ For patients who miss initial visits and wish to rebook, payment must be made in advance upon rescheduling in person.

____ Patients who are more than 15 minutes late will be charged the full fee of the length of their originally scheduled visit.

____ Please keep a copy of this policy with your medical files to avoid misunderstandings. Thank you for your cooperation.

Signature____ Date_______________________

INFORMED CONSENT (MINOR)

Alternative doctors assess the whole person, taking into consideration the physical, mental, emotional, and energetic aspects of an individual. Your doctor will conduct a thorough case history, physical exam and may request specific saliva tests to be used as part of the treatment work-up. It is important that you inform your doctor immediately of all disease process that your child may be experiencing, and of any medication, over the counter drugs or supplements s/he is taking.

Statement of Acknowledgement

As the guardian of a patient of this office who is below the age of majority, I have read the information about the health care to be provided and understand it is based on natural and other supportive principles and practices. I understand that a record will be kept of the health services provided to my child. This record will be kept confidential and will not be released to anyone other than Dr. Firnbach unless so directed by myself or unless law requires it. By signing below, I give my permission for her to discuss pertinent details of my child's case with another medical practitioner to make treatment decisions or a referral. I will inform the doctor if I have any concerns about these methods of enhancing my child's care. I understand that I may look at my child's medical records at any time and can request a copy of these by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in young children, or for those on multiple medications. The information I have provided about my child is complete and inclusive of all health concerns including risk of pregnancy, and all medications including over the counter drugs and supplements.

The slight health risks of some natural treatments include but are not limited to:
- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications of treatment. With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above for my child. I intend this consent form to cover the entire course of my child's treatment at this office. I also confirm that my child and I have the ability to accept or reject this care of our own free will and choice, and to discontinue participation in these procedures at any time. I accept full responsibility for any fees incurred during care and treatment and for missed appointments without 24 hours advance cancellation or emergency circumstances. By signing below and providing your credit card number, you acknowledge having read the cancellation/tardiness policy in full and your cooperation with this policy.

NAME of PATIENT (Please Print) ____

NAME of GUARDIAN (Please Print) ____

SIGNATURE of GUARDIAN ____DATE __________________

CREDIT CARD INFORMATION (for office use only) ____

EXPIRATION DATE ______________ CODE ________________