Vibrant Health
Naturopathic Medical Center
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Pediatric New Patient Intake Form

Personal Information

Date: _____

Name: _____ Nickname: _____

Child's Primary Address: _____

City: _____ State: _____ Zip Code: _____

Date of birth: _____ Age: _____ Name of School: _____Grade: _____

Mother's Name: _____ Occupation: _____

Ph #: H (____)_____ W (____)_____C (____)_____

Father's Name _____ Occupation: _____

Ph #: H (____)_____ W (____)_____C (____)_____

Email address: _____

Parents are: _____Married _____ Separated _____Divorced _____ Other Guardian

With whom does the child live?_____

Who is financially responsible for the child? _____

Emergency Contact

Name: _____ Relationship: _____

Phone #: H (____)_____ W (____)_____ C (____)_____

Address: _____

City, State, Zip:_____

Has your child been to a Naturopathic Doctor before? _____ If so, when? _____

What was treatment for? _____

Were you satisfied with care? _____ If not, please explain: _____

_____

Pediatrician's Name, PH # & Location: _____

_____

When was your child's last visit to this doctor and why? _____

_____

What is the reason for your visit today? _____

_____

_____

_____

List all hospitalizations and/or surgeries: _____

_____

_____

Health History

Please list any known allergies (environmental, drug, food, animals, chemicals/perfumes): _____

_____

Does your child take any of the following over-the-counter medications? Please check any that apply:

___Aspirin ___Ibuprofen or acetaminophen ___Antihistamine ____Laxatives ____Antacid

Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking or have taken in the last year.

Medication	*Dosage*	*Dates*	*Reason for taking*

Health of baby at birth: _____

Has your child ever been on antibiotics? Y N If yes, for what condition and at what age: _____

_____

Was child breastfed? Y N For how long? _____

Was child put on formula? Y N At what age? _____ What formula was used? _____

At what age did the child start solid food? _____ Did the child develop allergies? Y N

At what age did the child begin walking? _____ Talking? _____Develop teeth? _____

Age of first menses (if applicable): _____

Height: _____ Weight: _____ Weight one year ago: _____

Mother's Pregnancy History

Age at conception: _____

Did you smoke? Y N Drink coffee? Y N Use recreational drugs? Y N

Diabetes? Y N Nausea/vomiting? Y N Emotional stress? Y N

Preeclampsia? Y N Vaginal Birth? Y N Length of labor: _____

Traumatic birth? Y N Forceps/suction used? Y N

If birth was traumatic, please explain: _____

_____

Vaccination History

Has your child been vaccinated? ____Yes ____No _____Some (did not finish)

Please indicate which vaccines your child has had: **MMR:** Y N S **DPT:** Y N S **HIB:** Y N S **HEP B:** Y N S

POLIO: Y N S **CHICKEN POX:** Y N S OTHER: _____

Has your child ever had a reaction to a vaccine? _____ If so, explain: _____

_____

_____

Family History

_____Allergies
_____Tuberculosis
_____Diabetes
_____Obesity
_____Autoimmune Disease
_____Alcohol/Drug Abuse
_____Other

_____Cancer
_____Heart Disease
_____Depression
_____ ADHD.ADD
_____ Other

_____
_____
_____

Lifestyle History

Exercise: Y N _____ hours per week Activities: _____

_____

Watch TV: Y N _____ hours per week

Sleep: _____ hours per night Is this enough? ___ yes ___ no

Level of stress: _____ Low _____ Ave _____ High

# of meals/day: _____ Bowel movements/day: _____

Dietary restrictions: _____

_____

Toxic exposure: Y N Explain: _____

Major life change in last year: Y N Explain: _____

_____

Will your child part of the decision-making process? Y N

Who will attend the appointment: _____

Is the child cooperative? Y N Explain: _____

_____

Has your child had any negative interactions with other health providers? Y N Explain: _____

_____

Dr. Nicole Schertell ND, CCT & Dr. Johanna Mauss

HIPAA CONSENT FORM

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient: _____