INTAKE FORM

PEDIATRIC CONSULTATION

PATIENT INFORMATION

First Name _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone _____ Birthdate _____ Age _____

Gender _____ Email (parent) _____

Pediatrician _____ Phone _____

PARENT/GUARDIAN INFORMATION

First Name _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone# _____ Work Phone _____

Relationship to patient _____ Occupation _____

Marital Status: ○ Married ○ Separated ○ Divorced

Social Security# _____ Partner's Name _____

How did you hear about us? _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Alt. Phone _____

REASONS FOR SEAKING CARE *(Please list your main health concerns in priority order)*

PROBLEM/CONCERN/SYMPTOM	DATE OF ONSET
1.	
2.	
3.	
4.	
5.	
6.	
7.	

HEALTH HISTORY *(Please check symptoms you currently have or have had)*

- ☐ Acne
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Birth Defects
- ☐ Bone Fractures
- ☐ Chicken Pox
- ☐ Colic
- ☐ Constipation
- ☐ Cough/Wheeze
- ☐ Cradle Cap
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizzy Spells
- ☐ Eating Disorder
- ☐ Ear Infections
- ☐ Eczema
- ☐ Epilepsy/Seizure
- ☐ Fatigue
- ☐ Frequent Infections
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Fever
- ☐ Hyperactivity
- ☐ Insomnia
- ☐ Jaundice
- ☐ Learning Disorder
- ☐ Measles
- ☐ Moodiness
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rubella
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stuffy Nose
- ☐ Thrush
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Typhoid Fever
- ☐ Vomiting Spells
- ☐ Weight Gain/Loss
- ☐ Other: _____

IMMUNIZATIONS *(Please list types, dates given, and any known adverse reactions)*

CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS *(Please include dosages)*

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES *(Please include dates)*

ALLERGIES *(drugs, food, or other substances)*

PRENATAL/BIRTH/FEEDING HISTORY *(List any health problems mother experienced during pregnancy)*

Term of pregnancy: ○ Full ○ Premature ○ Late Birth Weight _____

List any complications with delivery: _____

Place of birth: ○ Hospital ○ Home ○ Clinic ○ Other _____

Feeding: ○ Breast (How long?) _____ ○ Formula (How long?) _____

Age solid foods began: _____ What foods? _____

List any food intolerances: _____

Favorite foods: _____

24-hour Food/Drink Intake (please list yesterday):

SOCIAL HISTORY

Are parents?: ○ Married ○ Separated ○ Divorced ○ Other: _____

Mother's Occupation: _____ ○ Full-time ○ Part-time

Father's Occupation: _____ ○ Full-time ○ Part-time

Guardian: _____ Relationship: _____

Others residing in home: _____ Relationship: _____

Daycare: ○ Yes ○ No Where?: _____

Siblings *(list names, ages, and any health problems below)*

FAMILY HISTORY *(Please check all that apply)*

- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Allergies/hay fever
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Ovarian cancer
- ☐ Prostate cancer
- ☐ Uterine cancer
- ☐ Other cancer: _____
- ☐ Diabetes
- ☐ Eczema
- ☐ Gout
- ☐ Heart disease
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Loss of height
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Senility
- ☐ Seizures
- ☐ Skin problems
- ☐ Stroke
- ☐ Suicide
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Ulcer
- ☐ Other: _____

OTHER INFORMATION *(list anything else you would like the doctor to know about you/your child)*

THANK YOU!

At Natural Paths to Wellness, we understand that unanticipated events occur in everyone's life. In our commitment to provide a quality experience to all of our clients and out of consideration for our Naturopaths' time, we have adopted the following policies:

1. A credit card will be required for all new patient appointments to guarantee your appointment and reserve that time for you. Your card will not be charged unless you fail to provide 24 hours notice of cancellation, however, you may use it to pay for services at the completion of your appointment.

2. 50% of the amount of the services scheduled for a new patient appointment and 100% of the amount of services scheduled for a return appointment will be charged in full for clients who "no-show" or fail to cancel their reservation within a 24-hour time period. The determined amount will be charged to the credit card on file.

3. Financial responsibility for services you receive at the office is yours alone and is **due at the time of service**. Cash, check, debit cards, and all major credit cards (except American Express) are accepted as forms of payment.

4. Please arrive for your appointment(s) on or before your scheduled starting time. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

CONSENT OF FINANCIAL RESPONSIBILITY

I have read the above statement and understand that i am financially responsible to natural paths to wellness for all care and services provided to me and/or my dependents.

Signature: _____ Date _____

Submit this form to Admin@NaturalPathsToWellness.com or fax to 717.430.0016