PEDIATRIC NEW PATIENT PACKET

Welcome to our Clinic!

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth:_____ Age:_____ Gender: Female / Male
Height:_____ Weight:_____

Parent/Guardian Contact Information:
Name _____Relationship to child _____
Address: _____
Home phone: (_____)_____-_____ Cell phone: (_____)_____-_____
E-mail: _____

HOW DID YOU HEAR ABOUT US?
_____

HEALTH HISTORY
What is the main reason for seeing the doctor today? If there is a specific health condition, please describe it in detail, including the first time you noticed the condition and anything you suspect played a role in its onset and continuation.
_____
_____
_____
_____

Please list other health conditions in order of importance:
1.)_____Onset: _____
2.)_____Onset: _____
3.)_____Onset: _____

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How would you describe your child's overall state of health? (please circle one)

Excellent Good Average Fair Poor

Who is the child's pediatrician?
Name: _____ Phone: _____

Has the child ever seen a naturopath, chiropractor, or acupuncturist before? Yes / No

ALLERGIES: List all drug, food and environmental allergies and the reaction to it:
_____
_____

PAST MEDICAL HISTORY
List any major illnesses with approx. dates: _____
_____
List any surgeries or operations with approx. dates: _____
_____
Past accidents or injuries: _____
_____

FAMILY HISTORY: Please list any medical conditions that run in your family (parents, siblings, grandparents, aunts and uncles): _____
_____
_____

MEDICATIONS/supplements/vitamins currently taking (please include dosage and how long the child has been taking it): _____
_____
_____

Typical food intake:

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other beverages:

Birth History:

At how many weeks gestation was the child born? ____ Circle One: Vaginal / C-Section

How much did he/she weigh? _____ How long in inches? _____

Were there any birth complications? _____

Was the child breast fed? Y / N If yes, for how long? _____

Were there difficulties introducing any foods? Which ones? _____

Immunization History
Has the child had all immunizations? Y / N

Please circle all administered: Hep B DTap/DTP Hib Polio MMR

Varicella (Chicken Pox) Other _____

Any reactions/complications from immunizations: _____

Clinic Policies & Agreements

Please read each section carefully and initial where indicated.

1. Payment Agreement

I understand that payment is due at the time of service for any services, tests, or medicinary items not covered by insurance. I acknowledge that a $25 fee will apply to any returned checks. All major credit cards are accepted.

Initial: _____

2. Medicinary Product Return Policy

For safety and quality assurance, once medicinary products (including supplements, homeopathics, and botanicals) leave the clinic, they cannot be returned or refunded.

Initial: _____

3. Cancellations & Missed Appointments

I agree to notify the clinic at least **24 hours in advance** if I need to cancel or reschedule an appointment. I understand that I will be charged a **$60 missed appointment fee** if I fail to do so.

Initial: _____

4. Email Communication

I understand that while email may be used for convenience in communication, it is not encrypted and may carry privacy risks. By initialing, I consent to the use of email for communication with my provider and other care team members involved in my treatment.

Initial: _____

Acknowledgment of Clinic Policies

I have read and understood the clinic policies above and agree to comply with them. I also consent to the release of my medical records to my insurance provider as required for billing and coordination of care.

Print Name: _____
Signature: _____
Date: _____

Informed Consent

Please read carefully before signing.

Naturopathic medicine and acupuncture use a variety of natural and integrative therapies intended to support the body's inherent ability to heal. While these methods are generally safe and effective when provided by a licensed practitioner, all treatments carry potential risks, and results cannot be guaranteed.

Therapies That May Be Used

Your care may include, but is not limited to, the following therapies:

- Nutritional supplements, botanical medicine, Chinese herbal medicine, and homeopathy
- Lifestyle counseling, dietary recommendations, and health education
- Naturopathic manipulative therapy and other physical medicine techniques
- Applied kinesiology, a clinical assessment method using gentle manual muscle testing as one component of evaluating functional imbalances in the body
- Acupuncture and traditional Chinese medicine techniques, including the use of sterile, single-use needles and moxibustion (the application of heat from burning herbal preparations near or on acupuncture points)
- Cupping therapy, which uses suction applied to the skin to support circulation and relieve muscle tension; temporary skin discoloration may occur
- Infrared light therapy, a non-invasive therapy using specific wavelengths of light to gently warm tissues and support circulation and relaxation
- Injection therapies, which may include vitamins, minerals, botanical substances, homeopathic remedies, or other substances within the practitioner's scope of practice
- Physical examinations and laboratory testing

Potential Risks May Include:

- Allergic reactions, sensitivities, or side effects related to supplements, herbs, injectable substances, or topical preparations
- Discomfort, bruising, bleeding, soreness, dizziness, or fainting associated with acupuncture or injection therapy
- Temporary worsening of symptoms or fatigue following treatment
- Infection, inflammation, or nerve irritation (rare) associated with needling or injections
- Interaction between naturopathic treatments and prescription or over-the-counter medications (please disclose **all** medications and supplements you are taking)

Alternatives:
I understand that alternatives to naturopathic and Chinese medicine care may include conventional medical treatment, other complementary therapies, or choosing no treatment at all.

Allergies:
Please list any known allergies or sensitivities (including medications, herbs, latex, or foods):
_____

_____

Consent:
I understand that naturopathic and Chinese medicine care is **not a guaranteed cure**, and that outcomes vary by individual. I have had the opportunity to ask questions about my care, and all of my questions have been answered to my satisfaction. I voluntarily consent to evaluation and treatment, and I authorize my provider to use their best clinical judgment in my care.

Print Name: _____
Signature of Patient or Parent/Guardian: _____
Date: _____

HIPAA Notice & Communication Preferences

We are committed to protecting your personal health information (PHI) as required under the **Health Insurance Portability and Accountability Act (HIPAA)**. Your information may be used for purposes such as:

- Coordinating care with other providers
- Communicating with your designated family members or caregivers
- Submitting insurance claims and obtaining payment
- Reporting certain public health concerns (e.g., flu outbreaks)
- Legal requirements (e.g., reporting gunshot wounds)

Please indicate your communication preferences:

(✓ or X all that apply)

☐ You may call me at home
☐ You may call my mobile phone
☐ You may leave a voicemail
☐ You may email me regarding my care
☐ You may send bills and medical correspondence by mail

Alternate phone number(s): _____
Alternate address (for billing or mail):

Other requests regarding communication or privacy:

Print Name: _____
Signature of Patient or Guardian: _____
Date: _____