Tree of Life Medicine

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PEDIATRIC INTAKE FORM

Patient's Name _____ Today's Date _____

Date of Birth _____ Age _____ Birth Sex _____

Parent's Name _____ Second Parent's Name _____

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ OK to leave message Y N

Email_____ Insurance:_____

Emergency Contact

Name_____ Phone _____

How did you hear about the clinic?

_____

Reason for referral or presenting problem(s)

_____

_____

_____

MEDICATIONS

	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	___	___
Tylenol	____	____	Anti-histamine	___	___
Decongestant	____	____	Other	___	___
Ibuprofen	____	____	List meds	_____	

_____

Allergies to meds _____

MEDICAL HISTORY

Childhood Illnesses:

___ Chicken Pox ___ Scarlet Fever ___ Tonsillitis
___ Measles ___ Pneumonia ___ Ear Infections
___ Mumps ___ Frequent colds ___ Other (please list)
___ Rubella ___ Rheumatic Fever

Has your child ever had any of the following tests?

When Where

EKG _____
EEG_____
Psychological Eval_____
Hearing_____
Speech/language_____

IMMUNIZATIONS

__ Hep B __ Polio __ DTaP __ Hib __ Rotavirus
__ PCV __ MMR __ Tetanus __ Influenza __ Hep A
__ Chicken Pox __ Other (list)_____

FAMILY HISTORY

__ Heart disease __ Diabetes __ Birth defects __Hypertension
__ Arthritis __ Tuberculosis __ Cancer __ Allergies
__ Eczema __ Asthma __ Mental illness

Previous pregnancies by natural mother, miscarriages or complications? _____
_____
_____

Mother's age at child's birth? _____ Father's age at child's birth?_____

Mother's health during pregnancy?

___ Bleeding ___ Physical or emotional trauma
___ Nausea ___ Cigarettes, alcohol, drug consumption
___ Illnesses ___ Medications
___ Hypertension ___ Thyroid problems
___ Diabetes

BIRTH HISTORY

Term: ___ Full ___ Premature ___ Late Weight at birth _____ lbs _____ oz

Length of labor _____ hours Complications? _____

_____

Has your child ever had any of the following problems?

__ Jaundice	__ Diarrhea	__ Birth defects	__ Rashes
__ Colic	__ Fever	__ Cerebral palsy	__ Allergies
__ Blue baby	__ Seizures	__ Birth injuries	__ Other (explain)

_____

Child's sleep pattern (first year) _____

Food intolerance (if any) _____

Feeding: Breast fed? _____ How long? _____ Formula: Milk Soy Other

Age began solid foods _____

Age began: Sitting _____ Crawling _____ Walking _____

First words _____

SYMPTOMS

(Mark 'C' for current and 'P' for past)

___ Hives	___ Burning of urine	___ Bloody urine
___ Eczema	___ Frequent urination	___ Cries easily
___ Bleeding of gums	___ Heart murmur	___ Nervous
___ Nose bleeds	___ Vomiting spells	___ Sleep problems
___ Acne	___ Anemia	___ Night sweats
___ High fevers	___ Stomach aches	___ Sensitive to light
___ Chronic rash	___ Jaundice	___ Body/breath odor
___ Hearing loss	___ Motion/car sickness	___ Easy bruising
___ Diarrhea	___ Flat feet	___ No appetite
___ Sore throat	___ Constipation	___ Nightmares
___ Frequent headaches	___ Gas	___ Canker sores
___ Frequent colds	___ Bleeding tendency	___ Unusual fears
___ Wheezing	___ Joint pain	___ Excessive fatigue
___ Cough	___ Dizzy spells	___ Hair loss

DIET

Please describe your child's typical daily diet including liquids:

_____

_____

_____

_____

_____

_____

Is there any information about your child or family situation that you would like to add?

_____

_____

_____

_____

_____

_____

_____

Welcome! We're happy to serve you. If you have any questions, please ask!

Terms and Conditions of Treatment

Consent for Treatment:

I understand that my care as a patient at Tree of Life Medicine is directed by Naturopathic Physicians, licensed acupuncturists, and/or other licensed professionals. I consent to services rendered and provided to me under the instructions of these professionals assisting in my care.

I may be contacted by Tree of Life Medicine' physicians for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Tree of Life Medicine in any way.

HIPAA Notice of Privacy Practices and Consent:

I hereby consent to the use and disclosure of my protected health information by Tree of Life Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

Statement of Financial Responsibility:

I understand and agree to the following:

- Payment for services rendered are my responsibility as the patient or patient's responsible party.
- I am responsible for paying for all services, including lab tests, rendered at the time of service.
- If I am receiving a discount of any sort, I am responsible for providing accurate and thorough documentation supporting it and I am responsible for paying in full at the time of service.

Insurance billing:

If I am billing insurance for services rendered, I understand and agree to the following:

- I authorize Tree of Life Medicine to release pertinent medical records related to billing directly to my insurance carrier. This release applies to support of the insurance billing process only.
- I am responsible for any and all charges that my insurance company will not cover.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date