Tree of Life Medicine

Dr Gabriel Archdeacon

174 River St. • Montpelier, VT 05602 • 802 505 0597 • 802-223-2016 fax

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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/HERBS/SUPPLEMENTS

1._____

2._____

3._____

4._____

5._____

Allergies to meds _____

MEDICAL HISTORY

Has your child ever had any of the following tests?

	When	Where
EKG/EEG		
Psychological Eval		
Hearing Eval		
Speech/language Eval		

IMMUNIZATIONS

Has your child had any of the recommended childhood vaccines? Yes No

If so, where can we obtain those records? _____

Has your child had any of the vaccine preventable illnesses? Yes No
(Chicken pox, measles, mumps, rubella, etc)

FAMILY HISTORY

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

Is your child exposed to second hand smoke in the home? Y N

Do you need assistance with resources for any of the following? (please circle)
Housing Food Transportation Other _____

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