Tree of Life Medicine
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PEDIATRIC INTAKE FORM

Patient's Name _____ Today's Date _____
Date of Birth _____ Age _____ Sex _____ S.S. # _____
Parent's Name _____ Second Parent's Name _____
Home Address _____
City _____ State ____ Zip Code _____
Phone (Home) _____(Other) _____ OK to leave message Y N
Email_____ Insurance:_____

How did you hear about the clinic?

_____

Name and Address of Dr.'s office/hospital/clinic where your child's health records are kept

_____

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

Has your child ever had any of the following tests?

	When	Where	Results
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.

I have fully read and understand the above agreements and authorizations.

_____

Patient (18 years or older) Date

_____

Parent, Guardian, Responsible Party Date

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.

_____

Signature of patient or patient's responsible party Date

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.

_____

Signature of patient or patient's responsible party Date

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.

_____

Signature of patient or patient's responsible party Date