Holistic Health Clinic
1530 South Union Avenue, Suite 4 • Tacoma, WA 98405 • (253) 752-2558

PEDIATRIC

Personal Information

Date _____ Birth Date _____ Age _____
Child's Name _____
Address _____
City _____ State _____ Zip _____
School _____

Responsible Party (first contact in case of emergency)

Name _____
Address _____
City _____ State _____ Zip _____
☐ Home Phone _____
☐ Work Phone _____
☐ Cell Phone _____
Mark the box next to the contact number above that is the best way to reach you, and is okay to leave a message.
Email Address _____
☐ Married/Partnered ☐ Single

Getting To Know You

Is another family member/relative a patient here?
☐ Yes ☐ No
Name _____
Referred by:
☐ Internet Search/Our Website ☐ Yellow Pages ☐ Sign
☐ Insurance Provider _____
☐ Family Member _____
☐ Friend _____
☐ Other (Explain) _____

Closest Relative Not Living With Child

Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Phone _____

Insurance

Primary Carrier _____
Insured's Name _____
Employer _____
Group # _____
ID # _____
List the name of your insurance's preferred Lab(s):
_____

Secondary Carrier _____
Insured's Name _____
Employer _____
Group # _____
ID # _____
List the name of your insurance's preferred Lab(s)
_____

Account Information

Name of Person Responsible for Account:
_____
Relationship _____
Occupation _____
Employer _____
Business Address _____
City _____ State _____ Zip _____
Business Phone _____

Additional Parental Information (Optional)

Name _____
Occupation _____
Employer _____
Business Address _____
City _____ State _____ Zip _____
Business Phone _____

Additional Person To Contact In Case Of Emergency (if responsibility listed above is not available)

Name _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____
Address _____
City _____ State _____ Zip _____

Authorization for Treatment

The undersigned has the legal authority and hereby authorizes the doctor to perform diagnostic test deemed necessary for this child's care, to perform any and all forms of treatment, medication, and therapy that are indicated and that I am in agreement with and are in accordance with the Standards of Naturopathic Care.

Patient's Name _____ Date _____
Signature of Parent or Responsible Party _____ Relation to Patient _____

Financial Policy

Payment: As a patient of this office you are directly responsible for payment of all charges incurred while under treatment unless you are eligible for insurance reimbursement with an insurance carrier the doctors have contracted with. Payments are due when services are rendered, supplies are received, or laboratory tests are ordered. If the doctor is contracted with your insurance carrier, all deductibles, co-pays and balances that are the patient's responsibility are due at the time of service. Accepted methods of payments are: personal checks, debit and credit Visa and Master cards, and cash.

Insurance: If the doctor is contracted with your insurance carrier we will bill your insurance directly. We will make every effort to determine benefits and eligibility prior to treatment. What we are told by your insurance carrier will govern how we determine your liability. We are not responsible for payment discrepancies that might occur once the reimbursement check is received. It is the patient's responsibility to keep tract of their deductible, maximum benefit, or other liabilities specific to their plan's coverage. If you are not covered by one of our contracted carriers and think that your insurance will cover naturopathic care, at your request we will provide you with an insurance billing form that you can submit to receive payment from your insurance company. (Weight Loss Programs are not covered by insurance.)

Senior Discount: A 10% discount on service (out-source lab, medications received from our dispensary and weight loss programs are not included) will be given to our patients who are age 65 or over. Due to State and Federal regulations, we cannot process medical coupons and Medicare/Medicaid claims.

Cancellations: Please give us at least 24 hours advance notice of your inability to keep an appointment. If less than 24 hours notice is received the amount of the scheduled visit will be charged (except in emergencies). Please initial that you understand this: _____

Late Fee: Accounts over ninety (90) days outstanding are overdue and may be acted on for collection. Collection costs are added to your account. A late fee of $1.50 or 1.0% of the balance per month, whichever is greater, is charged on overdue accounts. There is a $10.00 charge for returned checks and payment is due in the amount of the check plus the returned check fee within ten (10) working days.

Authorization for Treatment

I, the undersigned, hereby acknowledge that the care being provided at the Holistic Health Clinic is designed to improve my health or condition. I authorize the doctor to perform diagnostic tests deemed necessary for my care, to perform any and all forms of treatment, to include medication, and therapy that are indicated and that I am in agreement with and are in accordance with the Standards of Naturopathic Care. If procedures are performed, I have given my permission to do so and acknowledge that full disclosure of information has been made. I understand that every effort will be made by the office to fully disclose information about the procedures used. If I have questions about these procedures I will ask them until they are answered to my full satisfaction. I further acknowledge that there is no guarantee or warrantee, expressed or implied, concerning the outcome of any of the procedures used in the course of my care.

If while under the doctor's care I experience a medical emergency, I am to dial 911. If I have a medical concern I am to phone the office to report. If my concern occurs during after hours I will phone the office where instructions on how to contact the doctor can be obtained on the after hours message prompts.

I understand and agree to the above ***Financial Policy*** and ***Authorization for Treatment***. I will abide by its terms.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Patient (print) Responsible Party/relationship to patient (print)

_____ _____

Witness Date

Holistic Health Clinic •1530 South Union, Suite #4, Tacoma, WA 98405 • 253-752-2558

Date: _____

Confidential Pediatric Patient Health Record

Child's Name _____ Nickname _____ Age ____ Birth Date _____

Blood Type _____ Birth Sex _____ Gender Identity _____ Pronoun of Choice _____

# of Siblings _____ Names & Ages _____

List Child's Current Health Problems

Prioritize by listing the problems in order of importance.

1. _____ 3. _____

2. _____ 4. _____

Complete the following section for the top 3 problems (**Check** the bold **descriptors** that apply):

Problem #1: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____ ☐ **Constant?** or ☐ **Intermittent?**

☐ **Worsening** or ☐ **Improving?** Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

How does problem #1 effect your child's body / their life?: _____

_____

Office Use Only _____

_____

_____

Problem #2: _____ Date of Onset: _____

Describe: _____

_____

Cause: _____ ☐ **Constant?** or ☐ **Intermittent?**

☐ **Worsening** or ☐ **Improving?** Why? _____

_____

Rx / Surgery / Treatments tried & the results: _____

_____

Associated personal and/or family history: _____

_____

How does problem #2 effect your child's body / their life?: _____

_____

Office Use Only _____

_____

_____

Problem #3: _____ Date of Onset: _____

Describe: _____

Cause: _____ ☐ **Constant?** or ☐ **Intermittent?**

☐ **Worsening** or ☐ **Improving?** Why? _____

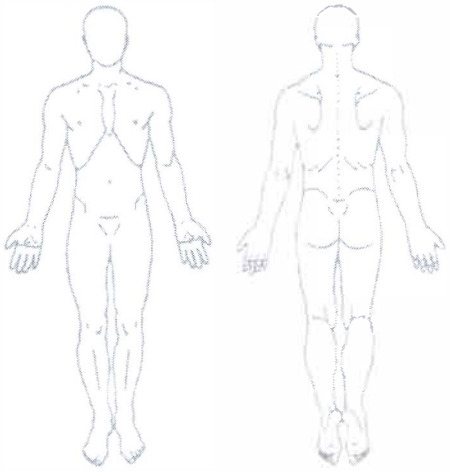
Rx / Surgery / Treatments tried & the results: _____

Associated personal and/or family history: _____

How does problem #3 effect your child's body / their life?: _____

Office Use Only _____

List any areas on your body where you feel any of the following sensations (leave blank if not relevant):



Numbness: _____

Deep Aching: _____

Burning: _____

Stabbing: _____

Pins & Needles: _____

Throbbing: _____

Itching: _____

General Information

Has your child seen a naturopathic doctor before? ☐ No ☐ Yes

Are they currently seeing one? ☐ No ☐ Yes Doctor's name: _____

Does your child have a medical doctor? ☐ No ☐ Yes Doctor's name: _____

Has your child seen a chiropractic doctor before? ☐ No ☐ Yes

Are they currently seeing one? ☐ No ☐ Yes Doctor's name: _____

Does your child see any other healthcare professional (i.e. acupuncturist, massage therapist, counselor)? ☐ No ☐ Yes

Explain: _____

What are the most significant measures that you have taken to improve your child's health? _____

Medications/Nutritional Supplements

List all prescribed meds – current & past: _____

List all "over the counter" Rx & supplements used: _____

Allergies to medications: _____

Review of Child's Body Systems

Please **check** all the problems your child **currently** has:

Constitutional ☐ Good general health ☐ Recent weight change ☐ Night sweats, fevers ☐ Fatigue/weakness ☐ Developmental disorders	**Ears / Nose / Mouth / Throat** ☐ Hearing loss or ringing ☐ Sinus problems ☐ Nose bleeds/bleeding gums ☐ Sore throat/voice change ☐ Canker/cold sores	**Eyes** ☐ Wear glasses/contacts ☐ Blurred/double vision ☐ Eye disease or injury ☐ Eye pain/dryness
Cardiovascular ☐ Chest pain ☐ Palpitations ☐ Heart trouble/murmur ☐ Swelling hands/feet ☐ Lightheaded/dizzy/faints	**Respiratory** ☐ Shortness of breath ☐ Cough ☐ Wheezing/Asthma ☐ Bad breath	**Gastrointestinal** ☐ Nausea/vomiting ☐ Abdominal pain/stomach aches ☐ Rectal bleeding ☐ No appetite ☐ Constipation/diarrhea
Musculoskeletal ☐ Muscle pain or cramps ☐ Stiffness/swelling joints ☐ Joint pain ☐ Trouble walking/flat feet ☐ Growth/bone disorders	**Neurological** ☐ Frequent headaches ☐ Paralysis or tremors ☐ Convulsions/seizures ☐ Numbness/tingling ☐ Motion/car sickness	**Hematologic / Lymphatic** ☐ Anemia ☐ Bruise easily ☐ Slow to heal ☐ Enlarged glands
Endocrine ☐ Excessive thirst/urination ☐ Hair loss ☐ Cold hands and feet ☐ Hormone problems ☐ Light sensitivity	**Integumentary/Skin** ☐ Abnormal nails ☐ Rashes or itching ☐ Acne ☐ Dry/discolored skin ☐ Body odor	**Allergic / Immunologic** ☐ Food allergies ☐ Frequent infections/colds ☐ Hay fever
Genitourinary ☐ Blood in urine ☐ Pain/burning on urination ☐ Frequent urination ☐ Kidney disease	**Genitourinary – Continued** ☐ Bed wetting ☐ Testicle/ovary pain ☐ Menstrual problems	**Psychiatric** ☐ Insomnia/nightmares ☐ Confusion/memory loss ☐ Depression/fears/cries easily ☐ Anxiety/panic attacks

Medical History

Check if your child has had any of the following:

☐ Chicken Pox	☐ Scarlet Fever	☐ Tonsillitis – # of times _____
☐ Measles	☐ Pneumonia	☐ Ear Infections – # of times _____
☐ Mumps	☐ Tuberculosis (TB)	☐ Rubella
☐ Hepatitis	☐ High Fevers	
☐ Rheumatic Fever	☐ Other: _____	

Has your child ever had any of the following tests?

	When:	Where:	Results:
EKG	_____	_____	_____
EEG	_____	_____	_____
Psychological Eval	_____	_____	_____
Hearing test	_____	_____	_____
Speech test	_____	_____	_____

Vaccinations

☐ Measles	☐ Polio	☐ MMR	☐ Diphtheria
☐ Mumps	☐ DPT	☐ Tetnus	☐ Hepatitis
☐ Influenza	☐ Other (list): _____		

Diet (Current) Please describe your childs typical diet (**Circle** foods that are craved/excessively consumed):

_____

_____

Any reactions to food? (Describe): _____

Personal | Family History (☐ Unknown – Adopted)

Please check and name who was affected (Self, Mother, Father, Grandparents, Sisters, Brothers, Children)

☐ AIDS/HIV _____
☐ Alcoholism _____
☐ Allergies _____
☐ Anemia _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer _____
☐ Depression _____
☐ Diabetes _____
☐ Drug Problems _____
☐ Eczema _____
☐ Gout _____
☐ Heart disease _____
☐ High blood pressure _____
☐ Hypoglycemia _____
☐ Kidney disorder _____
☐ Mental illness _____
☐ Migraines _____
☐ Obesity _____
☐ Psoriasis _____
☐ Senility _____
☐ Sex abuse _____
☐ Seizures _____
☐ Stroke _____
☐ Suicide _____
☐ TB _____
☐ Thyroid problems _____
☐ Ulcer _____
☐ Other _____

Menstrual/Reproductive History (Females only)

Age period began? _____ Date of last period: _____ Regular periods? ☐ Yes ☐ No ☐ Sometimes

Periods every _____ days (length of entire cycle) Flow: ☐ Heavy ☐ Medium ☐ Light Duration: _____ days

Spotting? ☐ Yes ☐ No Midcycle: ☐ Yes ☐ No Instead of period: ☐ Yes ☐ No Blotting?: ☐ Yes ☐ No

Cyclical pre-menstrual weight gain: ☐ Yes ☐ No How many pounds? _____

Cramps? ☐ Yes ☐ No Duration: _____ days Intensity: ☐ Mild ☐ Moderate ☐ Severe

PMS? ☐ Yes ☐ No Describe: _____

Birth History

Check if **mother** had any of the following problems during pregnancy. Mother's age at child's birth? _____

☐ Bleeding	☐ Illnesses	☐ Excessive weight	☐ Physical/emotional trauma
☐ Nausea	☐ Diabetes	☐ Thyroid problems	☐ Hypertension
☐ Cigarettes, alcohol, drug consumption (describe): _____			
☐ Medications (list): _____			

Pregnancy:

Term: ☐ Full ☐ Premature ☐ Late In Weeks _____ Weight at birth _____ lbs _____ oz

Length of labor: _____ hours Complications? _____

Check if your child had any of the following problems during their first 3 months of life:

☐ Jaundice	☐ Diarrhea	☐ Birth defects	☐ Rashes
☐ Colic	☐ Fever	☐ Cerebral palsy	☐ Allergies
☐ Blue baby	☐ Seizures	☐ Birth injuries	☐ Constipation
☐ Other: _____			

Child's sleep pattern (first year) _____

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

Age began solid foods _____ List first foods: _____

Food intolerance (if any) _____

Age began: Sitting _____ Crawling _____ Walking _____ First words _____

Is there anything else you would like the Doctor to know?

_____

_____