

Orchard Holistic Medicine
205 Bethel Ave, Port Orchard, WA 98366
360-602-2806

PEDIATRIC

Patient Information

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

Responsible Party (first contact in emergency)

Parent/Legal Guardian _____
Address _____
City _____ State _____ Zip _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____

Mark the box next to 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

Referred by:

Internet Search/Our Website Yellow Pages Sign
 Insurance Provider _____
 Family Member _____
 Friend _____
 Other (Explain) _____

Insurance

Primary Carrier _____
Insured's Name _____
ID # _____
Group # _____

Account Information

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

Additional Parental Information (Optional)

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

Closest Relative Not Living With Child:

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

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

Name _____ Relationship _____ Phone _____
Address _____ City _____ State _____ Zip _____

Authorization For Treatment

The undersigned has the legal authority and hereby authorizes the doctor to perform diagnostic tests 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 _____ Relationship 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 track 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).

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 Orchard Holistic Medicine 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 warranty, 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

Date: _____

Child's Name _____ Age _____ Birth Date _____ F M Blood Type _____

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: _____

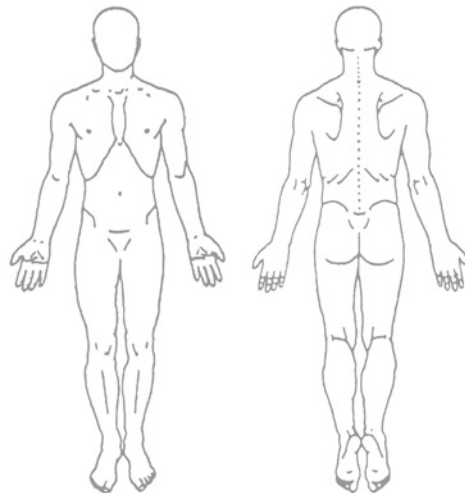
How does problem #3 effect your child's body / their life?: _____

Office Use Only _____

Use diagram to illustrate the areas on your child's body where they feel any of the following sensations:

Use the following letters to mark the diagram:

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

Medical History Check if your child has had any of the following (Circle if it has occurred in the past year):

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis - # of times _____
<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ear Infections - # of times _____
<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Rubella
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Fevers	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other: _____	

Has your child ever had any of the following tests?

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

Vaccinations

<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> MMR	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Mumps	<input type="checkbox"/> DPT	<input type="checkbox"/> Tetnus	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Influenza	<input type="checkbox"/> Other (list): _____		

Diet (Current) Please describe your child's 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)

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV _____ | <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Psoriasis _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Senility _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Sex abuse _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Arthritis _____ | _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney disorder _____ | <input type="checkbox"/> TB _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Mental illness _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Drug Problems _____ | <input type="checkbox"/> Obesity _____ | <input type="checkbox"/> 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? _____

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Illnesses	<input type="checkbox"/> Excessive weight	<input type="checkbox"/> Physical/emotional trauma
<input type="checkbox"/> Nausea	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cigarettes, alcohol, drug consumption (describe): _____			
<input type="checkbox"/> 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:

<input type="checkbox"/> Jaundice	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Rashes
<input type="checkbox"/> Colic	<input type="checkbox"/> Fever	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Allergies
<input type="checkbox"/> Blue baby	<input type="checkbox"/> Seizures	<input type="checkbox"/> Birth injuries	<input type="checkbox"/> Constipation
<input type="checkbox"/> 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?

