New Pediatric Patient Intake

Welcome! Holistic health care and preventive medicine are most effective when the doctor has a complete understanding of your child's health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential and will never be shared with any other party. Email addresses will only be used for contact regarding to your child's health care, if necessary.

Name _____ Preferred Name _____

Age _____ Date of Birth _____/____/_____ ☐ Female ☐ Male Social Security Number _____-_____-_____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home phone number _____ Is it OK to leave messages? ☐ Yes ☐ No

With whom does this child live? ☐ Mother ☐ Father ☐ Both parents ☐ Other _____

Emergency contact

Name _____ Relationship _____

Phone (Day) _____ (Evening) _____ (Cell) _____

Address _____

Email address _____

Preferred contact ☐ Day phone ☐ Evening phone ☐ Cell phone ☐ Email

Besides the Emergency Contact, who else has permission to bring your child to see Dr. Cimperman?

Name	Phone #	Relationship to child
_____	_____	_____
_____	_____	_____

Who may we thank for your referral?

☐ Friend or family
☐ Wisdom Magazine
☐ Other _____
☐ *Whole Living* magazine
☐ Naturopathic Gourmet Blog
☐ A Different Kind of Doctor Blog
☐ AANP
☐ NYANP
☐ NCNM
☐ AHMA

Conditions, symptoms, concerns (in order of priority)	Date of onset
(1)_____	_____
(2)_____	_____
(3)_____	_____
(4)_____	_____

Primary Care Physician:

Name _____ Clinic _____

Phone _____ Address _____

Have you consulted your PCP about the aforementioned condition(s)? ☐ No ☐ Yes

☐ My child does not have a PCP

Other practitioner(s) you have consulted about the aforementioned condition(s):

Name _____ Specialty _____ Clinic _____

Phone _____ Address _____

Diagnosis / treatment / results _____

_____

☐ Other practitioners listed on reverse

Have you been to a Naturopathic Doctor before? ☐ No ☐ Yes

Name _____ City _____

Phone _____ Dates of treatment _____

Diagnosis / treatment / results _____

_____

Where was your child born? ☐ Hospital ☐ Home ☐ Birth Center ☐ Other _____

Was your child breastfed? ☐ No ☐ Yes - How long? _____

Please indicate if your child has had the following conditions or symptoms by marking "C" for current, "P" for past, or "N" for never:

C	P	N		C	P	N	
☐	☐	☐	Anemia	☐	☐	☐	Gastrointestinal disorder
☐	☐	☐	Asthma	☐	☐	☐	Hay fever
☐	☐	☐	Autoimmune disease	☐	☐	☐	Headaches
☐	☐	☐	Cancer of _____	☐	☐	☐	Head injury
☐	☐	☐	Chicken pox	☐	☐	☐	Hypoglycemia
☐	☐	☐	Circulatory problems	☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Constipation	☐	☐	☐	Mononucleosis
☐	☐	☐	Colic	☐	☐	☐	Nausea
☐	☐	☐	Dental problems	☐	☐	☐	Neurological disease
☐	☐	☐	Diabetes	☐	☐	☐	Seizures
☐	☐	☐	Diarrhea	☐	☐	☐	Sinus problems
☐	☐	☐	Difficulty sleeping	☐	☐	☐	Skin problems
☐	☐	☐	Ear infections	☐	☐	☐	Strep throat
☐	☐	☐	Frequent antibiotic use	☐	☐	☐	Urinary tract infection
☐	☐	☐	Frequent colds or flu	☐	☐	☐	Other _____

Has you child been immunized? ☐ No ☐ Yes – Please check boxes and list age at vaccination below

☐ DTaP _____
☐ HIB _____
☐ Hep A _____
☐ Hep B _____
☐ HPV _____
☐ IPV (polio) _____
☐ Influenza _____
☐ MMR _____
☐ Meningococcal _____
☐ Pc (Pnuemonococcal) _____
☐ Rotavirus _____
☐ Varicella _____
☐ Other _____

Please list any known allergies:

Drug _____
Environmental _____
Food _____
Other _____

Lifestyle History

Height _____ Weight _____ BMI, if known _____

If your child has daily bowel movements, how many per day? _____
If your child does NOT have daily bowel movements, how many per week? _____
How would you describe them? Color _____
Check all that apply: ☐ Easy ☐ Difficult ☐ Painful ☐ Soft ☐ Dry and hard
☐ Loose ☐ Explosive ☐ Blood ☐ Mucus ☐ Undigested food ☐ Floats ☐ Sinks

What does your child regularly eat and drink? Note the typical time of day and describe all that apply:

Breakfast _____
Mid-morning snack _____
Lunch _____
Mid-afternoon snack _____
Dinner _____
Late-night snack _____

Current dietary restrictions _____
Why? _____
Past dietary restrictions _____
When? Why? _____

Where does your child eat? Check all that apply:
☐ Table ☐ Desk ☐ Bed ☐ In front of the TV ☐ Car ☐ Standing ☐ Walking
☐ Other _____

Sleep _____ hours per night
Are there any problems with sleep? ☐ No ☐ Yes _____

Describe your child's physical activity _____
_____

Is your child exposed to second hand smoke on a regular basis? ☐ No ☐ Yes

Mercury amalgam fillings ☐ Never ☐ Past ☐ Present

Does your child live in a new home or a newly remodeled home? ☐ No ☐ Yes

Do you have pets? ☐ No ☐ Yes _____

Does your child watch television? ☐ No ☐ Yes _____ hours per day

Major life change in last year? ☐ No ☐ Yes _____

What therapies have you tried? Please check "C" for therapies you currently use and "P" for those you have used in the past:

C	P		C	P	
☐	☐	Acupuncture	☐	☐	Homeopathy
☐	☐	Chiropractic	☐	☐	Hydrotherapy
☐	☐	Counseling	☐	☐	Physical Therapy
☐	☐	Detoxification	☐	☐	Supplements
☐	☐	Fasting	☐	☐	Other _____

Medications and Supplements

Please list all prescription medications, over-the-counter medicines, natural medicines, vitamins, and supplements your child is currently taking. Use a separate page if necessary.

Name	Dosage	Dates Taken	Reason for taking

☐ See reverse
☐ See attached page

Informed Consent

I, _____ (please print your name clearly), hereby certify by my signature at the bottom of this page that:

I understand Sarah Cimperman is a Doctor of Naturopathic Medicine and the state of New York does not recognize naturopathic doctors as licensed medical doctors. I understand that Dr. Cimperman functions as a health consultant and that she is not licensed to diagnose or treat specific diseases, prescribe drugs, or perform surgery in New York.

I understand that any assessment performed by Dr. Cimperman and any natural remedy recommended by Dr. Cimperman is for the purpose of optimizing my child's health, body function, and overall wellness, not for purposes of diagnosis, treatment, or replacement of prescription medication.

I understand that Dr. Cimperman's services are not a replacement for care by licensed medical providers. I understand that Dr. Cimperman advises me to maintain contact with a primary care physician on behalf of my child and seek treatment for any symptoms, complaints, and conditions that I feel require such care. I take responsibility for informing other medical providers of any natural remedy I allow my child to consume. I take responsibility for informing Dr. Cimperman of any changes in my child's health, medications and supplements while seeking her services.

I take full responsibility for giving my child any natural remedy Dr. Cimperman may recommend. I do not hold Dr. Cimperman accountable or liable for any adverse effects or complications from the natural remedies that my child consumes. I understand that results are not guaranteed.

I understand that Dr. Cimperman does not bill insurance and I agree to pay for her services at each visit, unless we have specified a different financial agreement prior to the appointment. I understand that there is a $50 fee for missed appointments and those canceled or rescheduled with less than 24 hours notice (48 hours for Monday appointments).

I understand that the internet is an open network and provides no inherent protection for confidential information. If I use email to communicate with Dr. Cimperman I understand that it may pose risks to the confidentiality of health information and I accept these risks. I understand that there will be times when she does not have access to e-mail and that I must contact her by telephone regarding critical or time-sensitive issues.

I sign this informed consent to express that I voluntarily seek naturopathic consultation from Dr. Cimperman on behalf of my child. I understand that I am free to withdraw my consent and to discontinue participation at any time.

I have read this consent form and fully understand its contents.

Patient name: _____

Date of birth: _____

Parent signature: _____

Date: _____