

INTAKE FORM

PEDIATRIC CONSULTATION

PATIENT INFORMATION

First Name _____ Last _____
Address _____
City _____ State _____ Zip _____
Phone _____ Birthdate _____ Age _____
Gender _____ Email (parent) _____
Pediatrician _____ Phone _____

PARENT/GUARDIAN INFORMATION

First Name _____ Last _____
Address _____
City _____ State _____ Zip _____
Phone# _____ Work Phone _____
Relationship to patient _____ Occupation _____
Marital Status: Married Separated Divorced
Social Security# _____ Partner's Name _____
How did you hear about us? _____

EMERGENCY CONTACT

Name _____ Relationship _____
Phone _____ Alt. Phone _____



REASONS FOR SEEKING CARE (Please list your main health concerns in priority order)

PROBLEM/CONCERN/SYMPTOM

DATE OF ONSET

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

HEALTH HISTORY (Please check symptoms you currently have or have had)

- | | | |
|----------------|---------------------|------------------|
| Acne | Dizzy Spells | Moodiness |
| Allergies | Eating Disorder | Mononucleosis |
| Anemia | Ear Infections | Mumps |
| Anorexia | Eczema | Pneumonia |
| Appendicitis | Epilepsy/Seizure | Rubella |
| Asthma | Fatigue | Rheumatic Fever |
| Bed Wetting | Frequent Infections | Scarlet Fever |
| Birth Defects | Headaches | Stuffy Nose |
| Bone Fractures | Heart Murmur | Thrush |
| Chicken Pox | Hepatitis | Thyroid Problems |
| Colic | Herpes | Tonsillitis |
| Constipation | High Fever | Typhoid Fever |
| Cough/Wheeze | Hyperactivity | Vomiting Spells |
| Cradle Cap | Insomnia | Weight Gain/Loss |
| Depression | Jaundice | Other: _____ |
| Diabetes | Learning Disorder | |
| Diarrhea | Measles | |

IMMUNIZATIONS (Please list types, dates given, and any known adverse reactions)



CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS (Please include dosages)

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES (Please include dates)

ALLERGIES (drugs, food, or other substances)

PRENATAL/BIRTH/FEEDING HISTORY (List any health problems mother experienced during pregnancy)

Term of pregnancy: Full Premature Late Birth Weight _____

List any complications with delivery: _____

Place of birth: Hospital Home Clinic Other _____

Feeding: Breast (How long?) _____ Formula (How long?) _____

Age solid foods began: _____ What foods? _____

List any food intolerances: _____

Favorite foods: _____

24-hour Food/Drink Intake (please list yesterday):



SOCIAL HISTORY

Are parents?: Married Separated Divorced Other: _____

Mother's Occupation: _____ Full-time Part-time

Father's Occupation: _____ Full-time Part-time

Guardian: _____ Relationship: _____

Others residing in home: _____ Relationship: _____

Daycare: Yes No Where?: _____

Siblings (*list names, ages, and any health problems below*)

FAMILY HISTORY (*Please check all that apply*)

- | | | |
|---------------------|---------------------|------------------|
| AIDS/HIV+ | Diabetes | Osteoporosis |
| Alcoholism | Eczema | Psoriasis |
| Allergies/hay fever | Gout | Senility |
| Arthritis | Heart disease | Seizures |
| Asthma | Hemophilia | Skin problems |
| Breast cancer | High blood pressure | Stroke |
| Cervical cancer | Kidney disease | Suicide |
| Ovarian cancer | Loss of height | Tuberculosis |
| Prostate cancer | Mental illness | Thyroid problems |
| Uterine cancer | Migraines | Ulcer |
| Other cancer: _____ | Obesity | Other: _____ |

OTHER INFORMATION (*list anything else you would like the doctor to know about you/your child*)



THANK YOU!

At Natural Paths to Wellness, we understand that unanticipated events occur in everyone's life. In our commitment to provide a quality experience to all of our clients and out of consideration for our Doctors' time, we have adopted the following policies:

1. A credit card will be required for all new patient appointments to reserve that time for you. Your card will not be charged unless you fail to provide a 24 business hour notice of cancellation. If you wish, you may use it to pay for services and/or supplements at the completion of your appointment.
2. \$155 for a new patient appointment and 100% of the amount of services scheduled for a return appointment will be charged in full for clients who "no-show" or fail to cancel within a 24 business hour time period. This does not include weekends. If you have to cancel an appointment for a Monday, please be sure to do it the business day prior. (Friday) The determined amount will be charged to the credit card on file.
3. Financial responsibility for services you receive at the office is yours alone and is **due at the time of service**. Cash, check, debit cards, and all major credit cards (except American Express) are accepted as forms of payment. Please note that insurance will not cover the cost of your services. If you have a FSA or HSA credit card, you may use that for payment, however, we can not guarantee that all plans will approve these expenses.
4. Please arrive for your appointment(s) on or before your scheduled starting time. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

CONSENT OF FINANCIAL RESPONSIBILITY

I have read the above statement and understand that i am financially responsible to natural paths to wellness for all care and services provided to me and/or my dependents.

Signature: _____ Date _____

Submit this form to Admin@NaturalPathsToWellness.com or fax to 717.430.0016

