

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: F M

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ Mother's Cell or Work: _____

Father's Cell or Work: _____

May we leave a message with phone numbers listed? Yes No

Parent's email address: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

Reason for referral or presenting problems: _____

MEDICATIONS

Aspirin Now Past Decongestants Now Past
Tylenol Now Past Anti-histamine Now Past
Antibiotics Now Past Other: _____
Ibuprofen Now Past Allergies to medicines: _____

MEDICAL HISTORY

Chicken pox Scarlet fever Tonsillitis, approx no. of times: _____
 Measles Pneumonia Ear infections, approx no. of times: _____
 Mumps Frequent colds Strep throat, approx no. of times: _____
 Rubella Rheumatic fever Other: _____

Has your child ever had any of the following?

WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS In the space to the right, state what age (months) the vaccination was received

MMR DPT Chicken pox Others: _____
 Measles Diphtheria Small pox Adverse reactions: Yes No
 Mumps Tetanus H. influenza If so, what? _____
 Rubella Polio The flu _____

FAMILY HISTORY

Heart disease Diabetes Birth defects
 Hypertension Arthritis Tuberculosis
 Cancer Mental Allergies Asthma
 illness Osteoporosis Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth: _____

Mother's health during pregnancy:

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |

BIRTH HISTORY

Term: Full Premature Late Length of labor: _____ Complications: _____

Birth city & state: _____ Birth time: _____ Birth weight: _____

Did your child have any of the following problems shortly after birth?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Other: _____ | | |

Child's sleep patterns (1st year): _____

Food intolerances: _____

Breast fed: Y N How long: _____ Formula: Y N Type (milk, soy): _____

Parent's email address: _____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite | <input type="checkbox"/> Body/breath odor | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies |

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

DENTAL HEALTH:

Do you have or have you had Cavities? Yes No

How many?

Amalgam fillings? _____

Composites? _____

Gold? _____

Dental health habits:

Brushing: how often _____

Flossing: how often _____

How often see dentist? _____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.

Ancient Traditions Natural Medicine

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you **do not** want us to attempt to reach you. Please check all that apply:

- Please do not phone me at home. Use this alternate phone number: _____
- Please do not phone me at work. Use this alternate phone number: _____
- Please do not leave messages on my answering machine.
- Please do not contact me by email.
- Please send mail, including my bills, to this alternate address:

Address: _____

City: _____ State: _____ Zip: _____

Other request (please describe):

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

____ / ____ / ____
Date

Informed Consent and Request for Naturopathic Medical Care, Classical Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Angela P. Lambert, ND, L.Ac, MSOM, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) by Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists or licensed massage therapists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Angela P. Lambert, ND, L.Ac, MSOM, and/ or with the allied health care provider providing backup:

- 1.) my suspected diagnosis(es) or condition(s)
- 2.) the nature, purpose, goals and potential benefits of the proposed care
- 3.) the inherent risks, complications, potential hazards or side effects of treatment or procedure
- 4.) the probability or likelihood of success
- 5.) reasonable available alternatives to the proposed treatment procedure
- 6.) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms)
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Angela P. Lambert, ND, L.Ac, MSOM, LMT, of these conditions. Please Initial:

- I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not licensed to prescribe any controlled substances.
- I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
- I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
- I understand that Dr. Angela P. Lambert, ND, L.Ac, MSOM is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Angela P. Lambert, ND, L.Ac, MSOM and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Lambert explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Printed Name of Patient _____ Signature of Patient _____

Printed Name of Guardian _____ Signature of Guardian _____

Date Signed _____