PEDIATRIC INTAKE FORM (6-12 years)

Name: _____ Date____/____/_____

Age: _____ Date of Birth: ____/____/____ Gender: F☐ M☐

Mother's name: _____ Father's name: _____

Address: _____

City: _____ State:_____ Zip Code:_____

Phone # (home): (_____)_____

Mother's # (work or cell): (_____)_____ Father's # (work or cell): (_____)_____

May we leave a message with phone numbers listed? Y☐ N☐

Parent's e-mail address: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

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

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Yes☐ No☐

If yes, what? _____

PREVIOUS ILLNESSES

Rheumatic fever	Yes ☐	No☐	German measles	Yes ☐	No☐
Chicken pox	Yes ☐	No☐	Measles	Yes ☐	No☐
Tonsillitis	Yes ☐	No☐	approx. number _____		
Ear infections	Yes ☐	No☐	approx. number _____		
Other	Yes ☐	No☐	list _____		

Has your child had any of the following tests? When Where

Electroencephalogram (EEG) _____

Psychological evaluation _____

Hearing tests _____

Speech/Language tests _____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

_____

_____

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

Polio	Yes ☐	No☐	Pertussis	Yes ☐	No☐
Tetanus shot	Yes ☐	No☐	Diphtheria	Yes ☐	No☐
Measles/Mumps/Rubella	Yes ☐	No☐	Influenza	Yes ☐	No☐
Any adverse reactions?	Yes ☐	No☐	If yes, what ? _____		

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals**?** _____

Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking, including brand names

1)_____

2)_____

3)_____

4)_____

5)_____

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? _____

REVIEW OF SYSTEMS

Y = a condition now **P** = significant problem in the past **N** = never had **S**= Sometimes a problem

MENTAL/ EMOTIONAL

Mood Swings Y☐N☐P☐S☐
Irritability Y☐N☐P☐S☐

Hyperactivity Y☐N☐P☐S☐
Introvert/extrovert Y☐N☐P☐S☐
Motion/car sickness Y☐N☐P☐S☐
Anxiety/nervousness Y☐N☐P☐S☐
Cries easily Y☐N☐P☐S☐
Unusual fears Y☐N☐P☐S☐
Sleep problems Y☐N☐P☐S☐
Nightmares Y☐N☐P☐S☐

ENDOCRINE

Heat/cold intolerance Y☐N☐P☐S☐
Fatigue Y☐N☐P☐S☐
Excessive thirst Y☐N☐P☐S☐
Excessive hunger Y☐N☐P☐S☐
Low blood sugar Y☐N☐P☐S☐
High blood sugar Y☐N☐P☐S☐

SKIN

Rashes Y☐N☐P☐S☐
Eczema, Hives Y☐N☐P☐S☐
Acne, Boils Y☐N☐P☐S☐
Itching Y☐N☐P☐S☐

HEAD

Headaches Y☐N☐P☐S☐
Head Injury Y☐N☐P☐S☐
Dizzy spells Y☐N☐P☐S☐
High fevers Y☐N☐P☐S☐

EYES

Glasses or contacts Y☐N☐P☐S☐
Tearing or dryness Y☐N☐P☐S☐
Eye pain/strain Y☐N☐P☐S☐

EARS

Earaches Y☐N☐P☐S☐
Impaired hearing Y☐N☐P☐S☐

NOSE AND SINUSES

Frequent colds Y☐N☐P☐S☐
Nose Bleeds Y☐N☐P☐S☐
Stuffiness Y☐N☐P☐S☐
Hay fever Y☐N☐P☐S☐
Sinus problems Y☐N☐P☐S☐
Loss of smell Y☐N☐P☐S☐

MOUTH AND THROAT

Frequent sore throat Y☐N☐P☐S☐
Canker sores Y☐N☐P☐S☐
Breath odor Y☐N☐P☐S☐

RESPIRATORY

Cough Y☐N☐P☐S☐
Wheezing Y☐N☐P☐S☐
Asthma Y☐N☐P☐S☐
Bronchitis Y☐N☐P☐S☐

CARDIOVASCULAR

Heart disease Y☐N☐P☐S☐
Murmurs Y☐N☐P☐S☐

URINARY

Frequent urination Y☐N☐P☐S☐
Bed wetting Y☐N☐P☐S☐

GASTROINTESTINAL

Belching/passing gas Y☐N☐P☐S☐
Stomach aches Y☐N☐P☐S☐
Constipation Y☐N☐P☐S☐
Diarrhea Y☐N☐P☐S☐
Bowel Movements Y☐N☐P☐S☐
How often _____

MUSCULOSKELETAL

Joint pain/stiffness Y☐N☐P☐S☐
Muscle spasms/cramps Y☐N☐P☐S☐
Broken bones Y☐N☐P☐S☐

BLOOD/PERIPHERAL VASCULAR

Anemia Y☐N☐P☐S☐
Easy bleeding/bruising Y☐N☐P☐S☐

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service for you and your child!

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

FEE SCHEDULE

Dear New Patient,

Welcome to Ancient Traditions Natural Medicine, LLC. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

New Patient Initial Naturopathic Visit, Infant-6 years: $275.00
New Patient Initial Naturopathic Visit, Age 6-12 years: $275.00
New Patient Initial Naturopathic Visit, Age 12-18 years: $325.00

Follow Up Naturopathic or Acupuncture Visit, Brief, 5-15 minutes: $65.00
Follow Up Naturopathic or Acupuncture Visit, Brief, 16-30 minutes: $90.00
Follow Up Naturopathic or Acupuncture Visit, Brief, 31-45 minutes: $115.00
Follow Up Naturopathic or Acupuncture Visit, Brief, 46-60 minutes: $140.00

Phone consultation AND email fees same as Return Visit Fees.
These prices include discounts for fees paid in full on the Day of Service.
If your account is not paid in full on the Day of Service, additional charges may be added.

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa, MasterCard, Amex. Returned checks will be subject to a $35.00 NSF fee.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

_____ You will be charged a Missed Appointment Fee of $60.00 for any missed appointments or late cancellations (less than 24 hours' notice).

_____ I understand that I am expected to have a local primary care physician if I am conducting my appointments with Dr. Lambert by phone, Skype, or any other electronic means.

I have read and understand the above-stated payment policies of Ancient Traditions Natural Medicine, LLC and will comply with them in all respects.

_____
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