Patient's Name:	Gender:
Current Pediatrician's Name:	Pediatrician's Phone:
	Pediatrician's Address:

With whom does the child live?

Name:	Age:
Relationship to child:	

Health History

Date of last medical or health care visit:

Date of last physical exam:

Does your child have any special needs? No / Yes

_____

_____

Has your child had any major illnesses, surgeries, hospitalizations, imaging (x-rays, CAT scans, MRI) or traumas. (Please list with dates and age.)

_____

_____

Ongoing Concerns (prioritized)

Concern	Started when?	Frequency?	How severe?
Headaches	*June 2010*	*4 per week*	*mild/mod/severe*

Are there any health concerns you'd like to discuss privately away from your child?

_____

_____

Any diagnosis made by previous doctors?

Diagnosis	Date

Medications or supplements (including past medications)

Name	Reason for Taking	Date Started/Discontinued

Any allergies to medications or supplements?

_____

_____

Other allergies? (Environmental, Food)

_____

Immunizations

□ Inactivated Polio (IPV) □ MMR (Measles, Mumps, Rubella) □ Flu Vaccine
□ Pneumoccocal (PCV) □ Rotavirus (RV) □ Smallpox □ HPV
□ HepA □ Hepatitis B (HepB) □ Varicella – Chicken Pox □ Tdap (Tetanus, Diptheria, Pertussis) □ Other_____

Prenatal history

□ Pregnancies #____ □ Miscarriages #____ □ Complications with other pregnancies?

Mother's age at child's birth: _____
Mother's health during pregnancy:

___ bleeding	___ nausea	___ physical or emotional trauma
___ illnesses	___ hypertension	___ cigarettes, alcohol, drug consumption
___ medications	___ diabetes	___ thyroid problems

Birth History

Term: ___ Full ___ Premature ___ Late Child's birth weight:_____
Length of labor: _____ ___ vaginal birth ___ C-section
Complications:_____
Did your child have any of the following problems shortly after birth?

___ Rashes	___ Birth injuries	___ Blue baby
___ Jaundice	___ Seizures	___ Cerebral palsy
___ Colic	___ Fever	___ Birth Defects

___ Other: _____
Breast fed: Y / N How Long:_____ Formula: Y / N Type (milk, soy):_____
Age began solids: _____ Which foods:_____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

Average hours of sleep: _____ Sleep well? Yes / No Nightmares? Yes / No

Lifestyle

What does your child enjoy doing (activities and hobbies)?

Does your child have any fears? No Yes _____

Play/Exercise: What kind and how often? _____

Video Games/TV : Yes / No How many hours per day? _____

How would you rate your child's overall health on a scale 1-10, with 10 being the highest? _____

How would you rate your child's academic performance on a scale 1-10? _____

What does your child typically eat?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Favorite Foods: _____

Adolescents:

Young women:

Menarche? N Y Age: _____ Any issues or concerns: _____

LMP: _____

Young Men:

Puberty? N Y Age: _____ Any issues or concerns: _____

Review of Systems

Please circle "Y" for Yes if symptom or illness is Currently experienced or "P" for Past symptom or illness your child has experienced.

Mood Swings Y P	Irritability Y P	Hyperactivity Y P
Anxiety Y P	Sleep Problems Y P	Fatigue Y P
Rashes Y P	Eczema Y P	Acne/ Boils Y P
Headaches Y P	Head Injury Y P	Dizzy Spells Y P
Earaches Y P	Frequent Colds Y P	Nose Bleeds Y P
Hayfever Y P	Sinus Problems Y P	Sore Throat Y P
Canker sores Y P	Breath Odor Y P	Cough Y P
Wheezing Y P	Asthma Y P	Bronchitis Y P
Pneumonia Y P	Heart Disease Y P	Heart Murmurs Y P
Frequent Urination Y P	Bed Wetting Y P	Belching / Gas Y P
Stomach aches Y P	Constipation Y P	Diarrhea Y P
Joint pain/ stiffness Y P	Muscle Spasms Y P	Broken Bones Y P
Anemia Y P	Easy Bleeding Y P	Easy Bruising Y P

Family History

Please circle all that apply, Note which family member (ex Maternal Grandmother – MG) and specify known type of disease if indicated.

Allergies

Alcoholism

Anemia

Alzheimer's

Bleeding Disorder

Cancer_____

Celiac Disease

Crohns Disease

Colitis

Depression

Diabetes Type 1

Diabetes Type 2

Eczema

Epilepsy

Gout

Heart Disease

High Blood Pressure

High Cholesterol

Kidney disease

Lupus

Mental Disorder

Type?_____

Nervous System Disease

Type?_____

Obesity

Seizures

Stroke

Thyroid (Hyper/Hypo)

Other_____

Other_____

Is there anything else you'd like me to know about your child?

_____

_____

Thank you so much! We look forward to working with you and your child.

Clinic Policies for Naturopathic Medicine

We take a personal approach to care. It is not the policy of our office to manage medical care via email or a patient portal. While email can be an efficient method of communicating we believe we can best serve you face to face or over the phone if necessary. For non-medical issues our office staff can be reached at info@todayhealthandwellness.com

On occasion phone consults are requested of our providers. If such a consult is requested you will be responsible for a telephone visit fee, which may not covered by insurance. From time to time your provider may contact you by phone for a brief exchange of medical information. There is no fee for such a service.

Payment is due at the time of service. After your visit, you will checkout with our staff and be asked for any copays or co-insurance for the services performed. As a courtesy, Today will contact your insurance and have a quote of your benefits prepared. You are responsible for your portion of any fees at the time of the visit, minus portions covered by insurance. Additional fees for outside labs will may billed to you.

Your initial visit will include a complete discussion of your health history and current symptoms. Physical exams relating to your symptoms will likely be performed in this visit. Your provider will make a treatment plan tailored to you. Your provider may order labs in this appointment, which will be released and discussed with you in a follow-up office visit. It is not the policy of our clinic to release labs without interpretation by your provider.

If you need a prescription refill please call your pharmacy. They will fax us your request or send it electronically. In order for your provider to make an informed decision with ample time to review your medical record we need 2-3 business days notice for your refill or non-urgent referral request.

For records requests for other providers we will do our best to get these processed within 7 business days. However, please keep in mind that common standards allow for 30 days to fulfill these requests.

Letters of medical necessity for supplements will be completed within 7 business days.

I acknowledge that I have read and understand the clinic policies for naturopathic medicine at Today Integrative Health + Wellness and have discussed any concerns or questions I have with the office staff.

Signature _____ Date _____

CONSENT FOR NATUROPATHIC TREATMENT

General Information: Today Integrative Health + Wellness is an Integrative Medical Clinic which integrates a number of medical modalities. Due to the diversity of modalities offered at Today, your treatment may include any or all of the following general modalities: Naturopatic Medicine, Physical Medicine, Therepeutic Exercise, Homeopathy, Psychological Counseling, Nutrional Counseling, and Intravenous Therapies.

Methods, Procedures, and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnositc Procedures: Including but not limited to venipuncture, pap smears, radiography, blood labwork, urine labwork, general physical exams, neurological and musculoskeletal assessments.

Herbs/ Natural Medicines: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substances, may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment (may include intramuscular injection or intravenous therapies).

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle energy stretching, visceral manipulation, as well as manipulations of the extremities and spine including traction and cranio-sacral therapy.

Electromagnetic and Thermal Therapies: Including the use of ultrasound, low and high-volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies.

Pharmaceutical Medication: Your physician may prescribe medication for your care that is within the scope of practice.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Pain, discomfort, blistering, discoloration, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies ,electromagnetic, and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Notice to Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy or during breast feeding.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been giving to me by Today or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or as otherwise permitted or required by law.

_____	_____
Patient Name (PRINT)	Guardian/Personal Representative (PRINT)
_____	_____
Patient Signature	Guardian/Personal Representative Signature
_____	_____
Date	Relationship/ Representative Authority