LLC

Date ___________

PEDIATRIC PATIENT PROFILE

A note to parents: Please complete this *three-sided* questionnaire as thoroughly as possible. This is a confidential record of your child's medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Patient's Name: ____
Nickname: ____________Date of Birth: ___/___/___ Age: ______ Gender: M ☐ F ☐
Address: _________________________ City:___________ State: _____ Zip: ______
Mother's name: __________________________________ Phone: ________________
Father's name: ___________________________________ Phone: ________________
Email: _________________________ I would like to receive quarterly E-newsletters [ ]

Please circle the phone number(s) at which detailed messages about your child's medical care may be left at.

Other current health care providers: ____

____

How did you hear about the Northeast Center for Holistic Medicine? _______________

____

Reason for visit: ____

____

Please continue on the following pages with your child's health history and information.

PRESENT HEALTH CONCERNS

What goals do you have for your visit at the Northeast Center for Holistic Medicine today? ____________

____

Symptoms:

Now	Past		Now	Past		Now	Past	
☐	☐	Acne	☐	☐	Excessive fatigue	☐	☐	Nervousness
☐	☐	Anemia	☐	☐	Ear infections	☐	☐	Night sweats
☐	☐	Bleeding gums	☐	☐	Frequent colds	☐	☐	Nightmares
☐	☐	Bleeding tendancy	☐	☐	Frequent headaches	☐	☐	Nose bleeds
☐	☐	Bloody urine	☐	☐	Gas, colic	☐	☐	Rashes
☐	☐	Body/ breath odor	☐	☐	Hay fever	☐	☐	Runny/stuffy nose
☐	☐	Burning urination	☐	☐	Hair loss	☐	☐	Sensitive to light
☐	☐	Canker sores	☐	☐	Hearing loss	☐	☐	Sleep problems
☐	☐	Cough	☐	☐	Heart murmur	☐	☐	Sore throats
☐	☐	Constipation	☐	☐	Hives	☐	☐	Stomach aches
☐	☐	Cries easily	☐	☐	Jaundice	☐	☐	Teeth problems
☐	☐	Dizzy spells	☐	☐	Joint pain	☐	☐	Unusual fears
☐	☐	Diarrhea	☐	☐	Lack of appetite	☐	☐	Vomiting spells
☐	☐	Easy bruising	☐	☐	Motion sickness	☐	☐	Wheezing
☐	☐	Eczema	☐	☐	Muscle/bone pain	Other: ____________		

Medical History

Medications:	**Now**	**Past**
Antibiotics	☐	☐
Antihistamines	☐	☐
Aspirin	☐	☐
Decongestant	☐	☐
Ibuprofen	☐	☐
Tylenol	☐	☐

Other Medications and Supplements:

____
____
____
____
____
____

Do your child have any allergies (medications, foods, etc) that are severe/ life threatening: **YES** **NO**
If yes, please describe: ________________________________

Immunizations:

☐ Polio	☐ MMR	☐ HIB	☐ Hepatitis B
☐ DPT	☐ Tetanus	☐ Chicken Pox	☐ Other: ____________

Childhood Illnesses (Please check if your child has had the following illnesses):

☐ Chicken Pox	☐ Measles	☐ Mumps	☐ Rubella
☐ Scarlett Fever	☐ Pneumonia	☐ Frequent Colds	☐ Rheumatic Fever
☐ Tonsilitis/ Strep Throat # of times _______		☐ Ear Infections # of times _______	

Has your child had any of the following tests?

	When?	**Where?**	**Results**
Electroencephalogram (EEG)			
Physchological evaluation			
Hearing			
Speech/Language			
Vision			

Past injuries/surgeries/hospitalizations: ________________________________

____

<u>Pregnancy History:</u>

Pregnancies by birth mother: _______ Miscarraiges or complications: ____________________________

Mother's age at childbirth: __________ Birth Medications (please list): ____________________________

Mother's health during pregnancy:

☐ Bleeding ☐ Nausea ☐ Diabetes ☐ Hypertension

☐ Thyroid problems ☐ Physical or emotional trauma ☐ Cigarettes, alcohol, or drug consumption

<u>Birth History:</u>

Term: ☐ Early ☐ Full ☐ Late Weight at birth: ______ lbs. _______ oz.

Length or labor: ___________ Complications: ____

Has your child had any of the following problems?

☐ Birth defects ☐ Allergies ☐ Diarrhea ☐ Rashes

☐ Birth Injuries ☐ Colic ☐ Fever ☐ Seizures

☐ Blue baby ☐ Cerebral Palsy ☐ Jaundice ☐ Other

Details: ____

____

Child's sleep patterns (first year): ____

Feeding: Breastfed? Y N How long? _______________ Formula fed? Y N milk / soy / other

Age your child began: Solid Foods: _______ Sitting: ______ Crawling: ______

Walking: __________ First words: __________________________

Please describe your child's typical diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: AM______________________Afternoon_______________________Evening________________

Typical Fluid intake daily: _________________________

Urination/day: ___ # Bowel movements/day: ___ Color: ________ Blood in stool? Y N Mucous? Y N

<u>Family History</u>

☐ Allergies ☐ Cancer ☐ Hepatitis ☐ Mental Illness

☐ Birth Defects ☐ Diabetes ☐ Hypertension ☐ Tuberculosis

☐ Arthritis ☐ Heart Disease ☐ Hypoglycemia ☐ Other

Details: ____

____

Any other details about your child that we should know about before meeting him/her?

We look forward to meeting you at your visit!

LLC

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www.northeastintegrative.com

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use of disclosure of my identifiable health information by the Northeast Center for Holistic Medicine, LLC for the purposes of diagnosis or provising treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at Northeast Center for Holistic Medicine, LLC may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Acupuncturist, Medical Doctor, Chiropractic Doctor, Osteopathic Doctor, Massage Therapist or other healthcare worker employed by or under contract with the Northeast Center for Holistic Medicine, LLC.

Patient means any person seeking the health care advice and/or treatment of a practitioner at the Northeast Center for Holistic Medicine, LLC through consultation by phone or in person.

My *identifiable health information* means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This *identifiable health information* relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Northeast Center for Holistic Medicine, LLC is not required to agree to the restrictions that I may request. However, if the Northeast Center for Holistic Medicine, LLC agrees to a restriction that I request, the restriction is binding upon the Northeast Center for Holistic Medicine, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that the Northeast Center for Holistic Medicine, LLC has taken action in reliance of this consent.

I understand that I have the right to review the Northeast Center for Holistic Medicine, LLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Northeast Center for Holistic Medicine, LLC.

Northeast Center for Holistic Medicine, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care: Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, and American Express.

We are currently unable to bill insurance in the states of New Hampshire and Massachusetts.

- Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- The Northeast Center for Holistic Medicine, LLC does not guarantee reimbursement by the patient's insurance company.
- I understand that it is not the responsibility of the Northeast Center for Holistic Medicine, LLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

Cancellation Policy:

The Northeast Center for Holistic Medicine, LLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

____ ________________

Signature of Patient or Authorized Representative Date

____

Printed name and relationship to patient