

Happy N' Healthy Naturopathy
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PEDIATRIC INTAKE FORM

6-12 years

Patient's Name: _____ Date: _____

Age: ____ Date of Birth: ____ / ____ / ____ sex: female male

Mother's name: _____ Father's name _____

Legal guardian name if applicable _____

Address: _____

City: _____ State: ____ Zip _____

Home Phone (____) _____ Work Phone(____) _____

How did you hear about this clinic: _____

Does your child have a contagious disease at this time?.....Y N

If yes, what? _____

Medical Concerns – What are the top concerns that you would like addressed?

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Previous Illnesses

Rheumatic fever German measles Measles Tonsillitis: approx. number _____ Ear infections: approx. number _____ Other: list _____

Has your child had any of the following tests?

Electroencephalogram (EEG) _____

Psychological evaluation _____

Hearing tests Speech/Language tests _____

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations Polio Pertussis Tetanus shot Diphtheria Measles/Mumps/Rubella
 Influenza Chicken pox

Any adverse reactions? Y N If yes, what? _____

Allergies

Is your child hypersensitive or allergic to Any drugs? _____

Any foods? _____

Any environmental? _____

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.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

REVIEW OF SYSTEMS Y = a condition now P = a condition in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings.....Y P N Anxiety/nervousness.....Y P N Irritability..... Y P N

Cries easily.....Y P N Hyperactivity.....Y P N Unusual fears..... Y P N

Introvert/extrovert.....Y P N Sleep problems.....Y P N Nightmares..... Y P N

Motion/car sickness.....Y P N

ENDOCRINE

Heat/cold intolerance.....Y P N Fatigue.....Y P N High blood sugar.. Y P N

Excessive thirst.....Y P N Excessive hunger.....Y P N Low blood sugar... Y P N

SKIN

Rashes.....Y P N Eczema, Hives.....Y P N Acne, Boils..... Y P N

Itching.....Y P N

HEAD

Headaches.....Y P N Head Injury.....Y P N Dizzy spells..... Y P N

High fevers.....Y P N

EYES

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

EARS

Earaches.....Y P N Impaired hearing.....Y P N

NOSE AND SINUSES

Frequent colds.....Y P N Nose Bleeds.....Y P N Stuffiness..... Y P N

Hayfever.....Y P N Sinus problems.....Y P N Loss of smell..... Y P N

MOUTH AND THROAT

Frequent sore throat.....Y P N Canker sores.....Y P N Breath odor..... Y P N

RESPIRATORY

Cough.....Y P N Wheezing.....Y P N Asthma..... Y P N

Bronchitis.....Y P N

CARDIOVASCULAR

Heart disease.....Y P N Murmurs.....Y P N

URINARY

Frequent urination.....Y P N Bed wetting.....Y P N

GASTROINTESTINAL

Belching/passing gas.....Y P N Stomach aches.....Y P N Constipation..... Y P N

Diarrhea.....Y P N Bowel Movements.....Y P N How often:_____

MUSCULOSKELETAL

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

BLOOD/PERIPHERAL VASCULAR

Anemia.....Y P N Easy bleeding/bruising....Y P N

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

Informed Consent

I acknowledge and understand that I have been informed and understand that:

1. Any education, advice or health plans provided to me as a client of Happy N' Healthy Naturopathy are **not** to replace medical care that I am receiving from another licensed health care provider or medical doctor.
2. Happy N' Healthy Naturopathy strongly recommends that I am an active patient of a licensed health care provider.
3. I agree to pay for any fees for service, costs of supplements, and remedies at time of service.

First Office Call, New Patient: Fee \$175

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient *has not been previously* seen at Happy N Healthy. It includes pertinent physical exams, possible lab test to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

First Office Call, *Established* Patient: fee \$120

This fee covers the first time a patient is seen by Dr. Sinclair, provided the patient is *already an established* patient at Happy N Healthy and has been referred by one of the Happy N Healthy Doctors or Nurse Practitioners. It includes pertinent physical exams, possible lab tests to be ordered (fee for labs is separate) and is approximately one and one half hours in length.

Return Office Call: fee \$80

This fee covers successive appointments with Dr. Sinclair. It is approximately one hour in length.

4. I have read the above information and consent to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures and medications before they occur or are prescribed, and include that information in the decision regarding my healthcare. I consent to treatment as agreed upon between Dr. Sinclair and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Sinclair.

Signature _____ **date:** _____
(Patient or Parent / Legal Guardian)

Print Name of patient _____