

# Happy N Healthy Naturopathy

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## New Patient Intake Form- Newborn- 5 year old

Name: \_\_\_\_\_ Gender: M F  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Names: \_\_\_\_\_  
Address: \_\_\_\_\_

Who does the child live with: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does the child have a medic alert? **Y/N**  
Or life threatening allergies? **Y/N**

### What's going on?

What is the main health concern? \_\_\_\_\_  
When did this begin? \_\_\_\_\_  
How long has this gone on for? \_\_\_\_\_  
What other treatments have been attempted? \_\_\_\_\_

What were the results with these treatments? \_\_\_\_\_

### What have child had? Check all applicable

- Chicken pox
- Measles
- Mumps
- Rubella
- Surgery
- Allergies

### Vaccinations: Check all applicable

- D-PTP (Diphtheria, Pertussis, Tetanus, Polio)
- Hib (H. influenza, often given with DPTP)
- MMR (Measles, Mumps, Rubella)
- Td + P (Tetanus, Diphtheria, Polio)
- OPV Hepatitis B
- Flu shot

Have the child ever been to the emergency room? **Y or N**

What was it for? \_\_\_\_\_

**What is the child taking?**

Please list any medications you have taken in the past and the ones currently being taken \_\_\_\_\_

\_\_\_\_\_

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking.

\_\_\_\_\_

**How was the child's birth?**

During the pregnancy was the mother exposed to any of the following: **Y or N**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcohol                | <input type="checkbox"/> Cigarette smoke          |
| <input type="checkbox"/> Recreational drugs     | <input type="checkbox"/> Prescription medications |
| <input type="checkbox"/> Over the Counter drugs | <input type="checkbox"/> Herbal preparations      |
| <input type="checkbox"/> Ultrasound             | <input type="checkbox"/> Amniocentesis            |
| <input type="checkbox"/> Illness                | <input type="checkbox"/> Large amount of stress   |

Were there any complications during the pregnancy? **Y or N**

- |   |   |
|---|---|
| <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Vomiting               | <input type="checkbox"/> Preeclampsia/eclampsia   |
| <input type="checkbox"/> Bleeding               | <input type="checkbox"/> Placenta previa          |
| <input type="checkbox"/> Gestational diabetes   | <input type="checkbox"/> Maternal rubella         |
| <input type="checkbox"/> Maternal chicken pox   | <input type="checkbox"/> Maternal cytomegalovirus |
| <input type="checkbox"/> Maternal toxoplasmosis | <input type="checkbox"/> Other                    |

**At Birth:**

Weight: \_\_\_\_\_

Length: \_\_\_\_\_

Were the child full term? \_\_\_\_\_ pre-term? \_\_\_\_\_ post-term? \_\_\_\_\_ premature? \_\_\_\_\_

Where did the birth take place? Home Hospital

What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth? **Y or N**

- |  |   |
|--|---|
| <input type="checkbox"/> Difficult delivery                  | <input type="checkbox"/> Breech delivery      |
| <input type="checkbox"/> Long 2 <sup>nd</sup> stage of labor | <input type="checkbox"/> Shoulder dislocation |
| <input type="checkbox"/> Forceps or suction used             | <input type="checkbox"/> Other                |

What were the APGAR scores? \_\_\_\_\_

Were any interventions administered at birth? Vitamin K Eye drops

What were the birth mother's feelings about the birth? \_\_\_\_\_

**As a Newborn:**

Did the child have any of the following conditions? **Y or N**

- Jaundice                       Colic
- Hip displacement             Meningitis
- Scoliosis

**What does the child like to eat?**

- As a baby were he/she breastfed? **Y or N**            For how long? \_\_\_\_\_
- Was he/she fed formula? **Yes or N**
- What kind of formula was used? \_\_\_\_\_
- Were there any reactions to the formulas? \_\_\_\_\_
- How old when were you introduced to food? \_\_\_\_\_
- What was eaten first? \_\_\_\_\_
- Were there any reactions to any foods? \_\_\_\_\_
- What is eaten now? \_\_\_\_\_
- What are some favorite foods? \_\_\_\_\_
- What are the least favorite foods? \_\_\_\_\_
- Are there any foods excluded for religious, ethnic or cultural reasons? \_\_\_\_\_
- \_\_\_\_\_

**Where does the child live?**

- What kind of a building (house, apartment, etc.)? \_\_\_\_\_
- How old is the building? \_\_\_\_\_
- Has it been renovated recently? \_\_\_\_\_
- Does the home have carpet? \_\_\_\_\_
- Has there ever been a problem with mildew in the home? \_\_\_\_\_

**What is the family like?**

- Has family member had any of the following diseases? **Y or N**
- Cancer     Diabetes     Heart Disease
- Stroke     Hypothyroidism     Arrhythmia
- Rheumatoid Arthritis     Hyperthyroidism     High blood pressure
- Lupus     Sickle-cell anemia     Crohn's Disease
- An Autoimmunedisease     Irritable Bowel Syndrome
- Ulcerative Colitis

**What does the child like to do?**

- In school? Which one? \_\_\_\_\_
- Daycare? \_\_\_\_\_
- Nanny? \_\_\_\_\_
- How does the child like playing with other kids? \_\_\_\_\_
- Do you have a pet? \_\_\_\_\_
- Does the child watch TV?            **Y or N** How often? \_\_\_\_\_
- Do the child play video games?    **Y or N** How often? \_\_\_\_\_
- Does the child play on the internet? **Y or N** How often? \_\_\_\_\_
- Do you have family time?            **Y or N** How often? \_\_\_\_\_

Does the child exercise? **Y or N**  
What? \_\_\_\_\_

What else do the child like to do? \_\_\_\_\_

**How is the child's sleep?**

What position does he/she like to sleep in? \_\_\_\_\_

How long (hours)? \_\_\_\_\_

How long to fall asleep? \_\_\_\_\_

Do the child wake up during the night? \_\_\_\_\_

Nightmares? \_\_\_\_\_

How does the child feel/ behave when awoken in the morning? \_\_\_\_\_

\_\_\_\_\_

Do he/she take naps? \_\_\_\_\_

How long? \_\_\_\_\_

What is the child's energy like during the day? \_\_\_\_\_

**From Head to Toe:** Please check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Cradle cap (seborrheic dermatitis) | <input type="checkbox"/> ADHD/ ADD              |
| <input type="checkbox"/> Eczema                             | <input type="checkbox"/> Urinary incontinence   |
| <input type="checkbox"/> Diaper rash                        | <input type="checkbox"/> Bedwetting             |
| <input type="checkbox"/> Yeast infection                    | <input type="checkbox"/> Fecal incontinence     |
| <input type="checkbox"/> Impetigo                           | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Conjunctivitis                     | <input type="checkbox"/> Paralysis              |
| <input type="checkbox"/> Autism /ASD                        | <input type="checkbox"/> Cerebral Palsy         |
| <input type="checkbox"/> Sinusitis                          | <input type="checkbox"/> Spina bifida           |
| <input type="checkbox"/> Ear infections                     | <input type="checkbox"/> Cystic Fibrosis        |
| <input type="checkbox"/> Chronic Colds                      | <input type="checkbox"/> Chronic Diarrhea       |
| <input type="checkbox"/> Croup                              | <input type="checkbox"/> Appendicitis           |
| <input type="checkbox"/> Bronchitis                         | <input type="checkbox"/> Constipation           |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Chronic Abdominal pain |
| <input type="checkbox"/> Pneumonia                          | <input type="checkbox"/> Short stature          |
| <input type="checkbox"/> Cardiovascular problems            | <input type="checkbox"/> Other                  |

## Informed Consent

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

Happy N' Healthy Naturopathy strongly recommends that I am an active patient of a licensed health care provider.

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. Klasman. 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.

### **Return Office Call: fee \$90**

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

### **Missed Appointment: fee \$50**

We do understand that there may be extenuating circumstances; however, we do request that any cancellation or change in your appointment be made 24 hours in advance. Patients that do not keep appointments or cancel with less than 24 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, the day before your appointment.

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. Klasman and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any concerns in my care with Dr. Klasman.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient or Parent / Legal Guardian)

**Print Name of patient** \_\_\_\_\_