

Happy N Healthy Naturopathy

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New Patient Intake Form- Pediatric (6 to 12 years of age)

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 or N

If yes, what? _____

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

1) _____ 2) _____

3) _____ 4) _____

5) _____ 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): **Y or N**

Psychological evaluation: **Y or N**

Hearing tests Speech/Language tests: **Y or N**

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 or N** If yes, what? _____

Allergies

Is your child hypersensitive or allergic to any drugs? **Y or N**

Any foods? **Y or N**

Anything environmental? **Y or N**

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) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 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
Dizzy spells..... Y P N

Head Injury.....Y P N
High fevers.....Y P N

EYES

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

Tearing or dryness.....Y P N

EARS

Earaches.....Y P N

Impaired hearing.....Y P N

NOSE AND SINUSES

Frequent colds.....Y P N
Stuffiness.....Y P N
Sinus problems.....Y P N

Nose Bleeds.....Y P N
Hayfever.....Y P N
Loss of smell.....Y P N

MOUTH AND THROAT

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

Canker sores.....Y P N

RESPIRATORY

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

Wheezing.....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
Constipation..... Y P N
Bowel Movements.....Y P N

Stomach aches.....Y P N
Diarrhea.....Y P N

MUSCULOSKELETAL

Joint pain/stiffness.....Y P N
Broken bones..... Y P N

Muscle spasms/cramps....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: 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 48 hours in advance. Patients that do not keep appointments or cancel with less than 48 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, a day or 2 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 _____