



west seattle
**NATURAL
MEDICINE**

Date: _____ **Sex:** M F **Age:** _____ **Birth date:** _____

Patient's Name: _____
First Name Middle Initial Last Name

Address: _____ **Phone (Home):** _____

City: _____ **State:** _____ **Zip:** _____

Mother's Name: _____ **Father's Name:** _____

In Case of Emergency: Name: _____ **Phone:** _____

What other healthcare is your child currently receiving? _____

Date of last Physical Exam: _____

A note to our patients: Naturopathic, holistic and preventative healthcare are only possible when the physician has a complete picture of the patient mentally, physically and emotionally. Please complete the questionnaire as thoroughly as possible. Thank You.

Present Health Concerns: In your opinion, what are your child's most important health concerns (in order of importance)? Also please indicate the problem that motivated you to bring your child in today.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Your Child's Health History: General health is Good Fair Poor

Childhood Illnesses: Mumps Pertussis Measles Rheumatic Fever Chicken Pox Diptheria
German Measles Pneumonia Mononucleosis Ear Infections Tonsillitis Other: _____

Surgeries (Year/Type): _____

Serious Illness or Injury (Year/Cause): _____

Hospitalizations (Year/Reason): _____

Medications: Please list all supplements, prescriptions, and non-prescription drugs and their dosage. (pills, liquids, ointments, suppositories, etc.)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Allergies: (List any allergies and their adverse effects (inhalants, food, drugs, chemicals etc.))

Immunizations: (Please give dates and adverse reactions for the following)

DPT _____	MMR _____	Polio _____
TB Test _____	HIB _____	Hep B _____
_____	Other _____	

Review of Systems: Please Circle **Y**-For a condition the child has now **P**-A condition the child had in the past. **N**-Never had

Weight:	_____	Cradle Cap:	Y	P	N	High Fever:	Y	P	N
Height:	_____	Depression:	Y	P	N	Hyperactivity:	Y	P	N
Acne :	Y P N	Diarrhea:	Y	P	N	Insomnia:	Y	P	N
Allergies:	Y P N	Ear Aches:	Y	P	N	Jaundice:	Y	P	N
Anemia:	Y P N	Eczema:	Y	P	N	Learning Disorder:	Y	P	N
Asthma:	Y P N	Epilepsy/Seizures:	Y	P	N	Moodiness:	Y	P	N
Bed Wetting:	Y P N	Fatigue :	Y	P	N	Stuffy Nose:	Y	P	N
Birth Defects:	Y P N	Frequent Infections:	Y	P	N	Thrush:	Y	P	N
Colic :	Y P N	Frequent Colds:	Y	P	N	Vomiting Spells:	Y	P	N
Constipation:	Y P N	Headaches:	Y	P	N	Other: _____			
Cough/Wheeze:	Y P N	Heart Murmur:	Y	P	N	_____			

Prenatal/Birth/Feeding History: Mother's health during pregnancy: Age: _____ Bleeding: Y N

Nausea: Y N Illness: Y N Toxemia: Y N Trauma/Injury: Y N Stress: Y N High Blood Pressure: Y N
 X-Rays: Y N Medications: Y N Alcohol Consumption: Y N Drugs: Y N Smoking: Y N

Other: _____

Term: Full Premature Late **Birth Weight:** _____ **Pregnancy was:** Easy Difficult

Place of Birth: Hospital _____ Clinic _____ Home or Other _____

Feeding: Brest Fed: Y N **How Long?** _____ **Formula Fed:** Y N **What Type?** _____

Age solid foods begun? _____ **What Kinds of Foods?** _____

Food Allergy/Intolerance: _____

Favorite Foods: _____

Social History: Parents: : Married Separated Divorced

Mother's Occupation: _____ Full time Part time

Father's Occupation: _____ Full time Part time

Other Guardian: _____ Relationship: _____

Others Residing in Home: _____ Relationship: _____

Daycare: _____ At what ages: _____ Hrs. per day _____ Days per week: _____

Preschool: _____ At what ages: _____ Hrs. per day _____ Days per week: _____

School: _____ At what age: _____ Hrs. per day _____ Days per week: _____

Siblings:	Name	Sex	Age	Health Concerns
1				
2				
3				
4				

Interaction with relatives: Who? _____

How often? _____

Do you have any other health concerns you would like to discuss? _____

Diet: Any diet restrictions or regimen? _____

Is your child satisfied with their diet as it is now? Y N **Do they eat three meals daily?** Y N

Do they crave Starches: Y N **Sweets:** Y N **Salt:** Y N **Fats:** Y N

Please write down two samples of each meal that your child eats nearly everyday. Include what they drink with their meals, desserts and snacks:

Breakfast: 1. _____ 2. _____

Morning Snack: 1. _____ 2. _____

Lunch: 1. _____ 2. _____

Afternoon Snack: 1. _____ 2. _____

Dinner: 1. _____ 2. _____

Late Snack/Dessert: 1. _____ 2. _____

What type of water do they drink: Tap Filtered Distilled Well **How many glasses per day?** _____

Do they drink soft drinks? Y N **How many per day/week?** _____ **Other beverages** _____

_____ **Do they salt your food?** Y N **If so, how much?** Light Moderate Heavy

Do they use artificial sweeteners? Y N **What kind?** _____ **How much?** _____

Describe their appetite in the: Morning _____ Noon _____ Evening _____

Sleep: Do they sleep well? Y N **Wake Rested?** Y N **Average Hours of Sleep (per 24 Hrs.)** _____

Exercise: Do they Exercise Regularly? Y N **What Type?** _____

_____ **How Long?** _____ **How Often?** _____

Family History:	Father	Mother	Brothers	Sisters
Age (If Living)				
Heath G-Good, P-Poor				
Age (At Death)				
Cause of Death				

Please identify known conditions within your family and list the family member's relationship to the child:

Cancer: Y N _____ **Mental Illness:** Y N _____

Diabetes: Y N _____ **Heart Disease:** Y N _____

Stroke: Y N _____ **Glaucoma:** Y N _____

Hives: Y N _____ **Kidney Disease:** Y N _____

Asthma: Y N _____ **Tuberculosis:** Y N _____

Hay Fever: Y N _____ **Physical Abuse:** Y N _____

Alcoholism: Y N _____ **Emotional Abuse:** Y N _____

High Blood Pressure: Y N _____ **Other:** _____

Does the child have any of the above? Y N **If yes, please list:** _____

Financial and Referral Policies

The policy of West Seattle Natural Medicine Clinic is to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard. We will bill all insurance companies that we are contracted with. ***It is your responsibility to contact your insurance company prior to your first office call so you know whether our services are covered under your plan.***

All dispensary products will be paid for at the time of pickup. If products are mailed, a Visa or MasterCard number will be required for purchase. Shipping and handling charges will apply. Dispensary products are non-returnable.

All checks returned for non-sufficient funds will result in a \$25.00 service charge to be collected by the next visit or within 30 days (whichever comes first).

If no payment is received on an account after 90 days, the account will be charged an interest rate of 15%. If there is still no payment made to the account after another 30 days the account will be sent to a collection agency.

Referral Policy: It is necessary to be seen by the Doctor for a health assessment and diagnosis before a referral can be given. If an emergent situation should arise, a call to request an emergency referral should suffice.

Note: A phone visit of greater than 5 minutes is reserved for those unable to get to the clinic, or with emergency needs. It is only for the use of established patients.

We will charge a lab-handling fee when appropriate; otherwise most labs will bill your insurance directly.

A fee of \$25.00 will be charged for cancellations made less than 24 hours from your scheduled appointment. **A no show fee of \$50.00 will be charged for patients who fail to show up for scheduled appointments.** Missed appointment charges are not covered by insurance.

I, _____, understand and willing to comply with above fees and payment procedures.

Signature: _____ Date: _____

Relationship to patient (circle one): Self Parent Legal Guardian Spouse Power of Attorney

Consent to use/and or Disclose Patient Information

As a patient of West Seattle Natural Medicine Clinic, you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of patient Privacy Practices.

You have the legal right to review our Notice of Patient Privacy Practice before signing this form. A copy of this Notice was made available to you along with this Consent. If you do not have copy of the Notice you can request one from us at the address and phone number given below.

We may change our Notice of Privacy Practice from time to time. If we do change it, we will make a copy of the revised Notice available to you the next time you are in the office for an appointment. You may obtain a copy of our current Notice upon request to our address or phone number given below.

You should read our Notice carefully before signing this form. As our Notice of Privacy Practice explains, we need your consent to use or disclose information about you so that we can provide you with health care treatment; arrange payment for your care and conduct certain kinds of administrative information about you these purposes.

You have a legal right to request us not to use or disclose information about you for some kinds of treatment, payment or health care operations purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing. Please contact us at the address and phone number below if you want more information, or to revoke this Consent.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment and health care operations.

Patient/Parent Signature: _____ Date: _____