Windrose Naturopathic Clinic
Family Practice – Preventative Care
1023 W Francis Ave, Spokane WA 99205 (509) 327-5143 (509) 327-9813 (fax)

50 years CELEBRATING Natural Healing

Date:_____

NEW PEDIATRIC PATIENT INFORMATION

To be filled out by parent or guardian:

Child's Name: _____ Age: _____ DoB: _____ Height: _____ Weight: _____

Address: _____

City, State, Zip _____ ❑ Male ❑ Female

Parent / Guardian Information:

Name: _____ Phone: _____ Relationship: _____

Address: _____ City, State, Zip _____

Parent's Email: _____

In case of emergency and neither parent can be reached, contact:

Name_____ Phone: _____ Relationship: _____

Pediatrician:

Name_____ Phone: _____ Can we contact: ❑ Yes ❑ No

How did you hear about us? _____

Pediatric/Adolescent Health History Intake Form

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____Date of Birth: _____ Age: _____Sex: _____ Today's Date: _____

PRENATAL HISTORY

A. Mother's Pregnancy: □Normal □Complications:_____
B. Gestation:_____weeks
C. Birth Location: □Hospital □Birthing Center □Home □Other_____
D. Delivery: □Vaginal □C-Section □Induced - Complications: □No □Yes_____
E. Birth Weight:_____lbs_____oz _____Length:_____inches

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. _____
2. _____
3. _____
4. _____

PAST MEDICAL HISTORY

MEDICATIONS: Please list all medication + over the counter medications that your child is taking with dosages.

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

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

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

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____
2. Environment: _____
3. Food: _____

PO Box 490, 120 Jackson River Road, Monterey, VA 24465
Phone 540-468-3300 - Fax 540-468-3301

Last Name:_____First Name:_____Date of Birth:_____

IMMUNIZATIONS

Please place an **X** next to each vaccination that your child has received. Please provide our office with a current vaccination history.

	Hepatitis A		Measles
	Hepatitis B		Mumps
	Diphtheria		Rubella
	Pertussis		Varicella (Chicken Pox)
	Tetanus		Influenza
	Haemophilus Influenza Type B		Rotovirus
	Polio		Human Papilloma Virus (HPV)
	Pneumococcal		

Has your child ever had a reaction to an immunization? □ Yes □ No

If so, which vaccine and what was the reaction:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age	Ear Infections:	No	Yes/Age
ADD:	No	Yes/Age	Eating Disorders:	No	Yes/Age
ADHD:	No	Yes/Age	Eczema:	No	Yes/Age
Alcohol use:	No	Yes/Age:	Headaches:	No	Yes/Age
Allergies:	No	Yes/Age	Head lice:	No	Yes/Age
Asthma:	No	Yes/Age	Mononucleosis:	No	Yes/Age
Bedwetting:	No	Yes/Age	Obesity/Overweight:	No	Yes/Age
Behavior problems:	No	Yes/Age	Pink eye:	No	Yes/Age
Bronchitis	No	Yes/Age	Pneumonia:	No	Yes/Age
Colic:	No	Yes/Age	Colds:	No	Yes/Age
Constipation:	No	Yes/Age:	Sinus Infection:	No	Yes/Age
Cough:	No	Yes/Age:	Thrush:	No	Yes/Age
Croup:	No	Yes/Age	Vomiting:	No	Yes/Age
Depression/ Anxiety	No	Yes/Age	Whooping cough:	No	Yes/Age
Diaper Rash:	No	Yes/Age:	Other Illness:		Age
Diarrhea	No	Yes/Age:	Other Illness:		Age
Drug Abuse	No	Yes/Age:			

Please comment on any illnesses indicated above: _____

_____

_____

_____

Last Name:_____First Name:_____Date of Birth:_____

PAST MEDICAL HISTORY

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS:

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

SURGERIES:

Type of Surgery	Date
_____	_____
_____	_____
_____	_____

LABS AND EXAM HISTORY:

Date of last well child check:_____ Date of last blood work: _____

Date of last urine test:_____ Date of last EKG:_____

Female Adolescents:

Date of last PAP and pelvic exam: _____

SOCIAL HISTORY

Parent's Marital Status:

□ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Living With:

□ Both Parents □ Mother □ Father □ Grandparents □ Foster Family □Other_____

Siblings (Indicate names and ages)

1. _____ 2. _____

3. _____ 4._____

5. _____ 6._____

Mother's Occupation: _____ Father's Occupation: _____

Guardian's Occupation:_____

Daycare Location:_____Days/Hours per week: _____

Last Name:_____First Name:_____Date of Birth:_____

SOCIAL HISTORY

NUTRITIONAL HISTORY:

Infant/Toddlers:

Type: □Nursing □Formula/Specify _____ □Both

Duration: □<15 min □15-30 min □30-45 min □45-60 min

Frequency: □Every hour □Every other hour □Every 3 hours □Every 4 hours □Every 5 hours

Amount of formula per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz

Have you started solids yet? If so what type _____

How much juice does your infant/toddler drink in a day _____ water _____

What type of milk does your child drink _____ How much per day _____

School Agers/Adolescents:

What is a typical breakfast_____

What is a typical lunch _____

What is a typical dinner _____

What are typical snacks _____

How many glasses of water do you drink each day _____

Do you have any special dietary restrictions _____

EXERCISE:

Do you exercise regularly? □ Yes □ No

What type/activity_____ How long _____How Often_____

SLEEP:

How many hours of sleep do you get at night on average _____

Do you have trouble falling asleep? □ No □ Yes/Why _____

How often do you wake up in the middle of the night and for what reasons _____

_____

Do you have trouble waking up? □ No □ Yes/Why _____

Do you feel rested when you wake up? □ Yes □ No/Why_____

ENERGY AND STRESS:

Adolescents:

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy?

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress?

How do you cope with stress?

TRAVEL HISTORY:

Identify any domestic or foreign travel and indicate year of travel:

Place: _____Year _____ Place: _____Year:_____

Last Name:_____First Name:_____Date of Birth:_____

SOCIAL HISTORY – School agers/Adolescents Only

SUBSTANE USE:
Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Soda:	P	C	Freq:_____	Tobacco:	P	C	Type/Freq_____
Coffee:	P	C	Freq: _____	Recreational Drugs:	P	C	Type/Freq_____
Alcohol:	P	C	Freq:_____	Other:	P	C	Type/Freq _____

BIRTH CONTROL:
Are you sexually active with □ Men □ Women □ Both
What form of contraception/birth control are you using (Check all that apply).
□ Withdrawal □ Condom □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch
□Fertility Awareness Method □ The Sponge □ Spermicide □ Diaphragm □ Cervical Cap
□ None

FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to your family members.

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Eczema							
Epilepsy							
Headaches							
Heart Disease							
Hepatitis							
High Blood							
Kidney Disease							
Stroke							
Tuberculosis							

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INFORMED CONSENT FOR TREATMENT

I,_____, hereby authorize the doctor's of The Windrose Naturopathic Clinic to perform the following specific procedures as necessary to facilitate my child's diagnosis and treatment(s):

Common diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.

Minor office procedures: e.g., dressing a wound, ear cleaning.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrition.

Botanical medicine: botanical substances my be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring elements to gently stimulate the body's healing responses, given orally, topically or by injection.

Lifestyle counseling and hygiene: promotion of wellness including recommendations for exercise, sleep, contraception, and stress reduction.

Psychological Counseling and /or the ordering of lap procedures, referral for x-ray, MRI, or other imaging, thermal imaging.

Naturopathic manipulation: specific manipulation of muscles and joints or soft tissue.

Naturopathic physiotherapy / hydrotherapy: the use of electromagnetic therapies, water applications, thermal or cryo-applications to stimulate healing.

Prescription of pharmaceuticals and / or bio-identical hormones.

I understand that treatment by a naturopathic doctor is intrinsically different from treatment by a conventional medical doctor. While naturopathic medicine is intrinsically safer than other systems of medicine, there are potential risks in what we do as well. The care we provide may, or may not be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore my child's body innate healing ability. We will always strive to provide full disclosure of all information relevant to your child's health care.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, healing reaction as defined below, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Healing Reaction: Natural healing may occasionally generate a "healing reaction." If this is anticipated, we will offer you specific information about this phenomenon. Generally this will occur as a flu-like state with fever or a worsening of symptoms for a few days. It can also, however be different than this and may require expert attention and guidance.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Pregnancy; Please tell us (if you know) if your child is pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures and that I realize that no guarantees have been given to me by the doctor's or staff of The Windrose Naturopathic Clinic regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Privacy Notice: The Windrose Naturopathic Clinic is required by law to respect your privacy by following specific HIPPA guidelines. A "Notice of Privacy Practices" document is available upon request.

_____ _____

Date Parent's Signature or Legal Guardian

_____ _____

Date Doctor's Signature

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FEES & FINANCIAL AGREEMENT

You have come to us for results. Like many before you, this has been a long journey and, more often than not, you have tried other medical solutions with little or no relief. We don't just treat symptoms with drugs that simply mask your child's underlying causes. ***We DO treat the underlying causes of your child's illness***.

We practice medicine differently from the typical medical model. First of all, we take considerably more time with you and your child. Most of our appointments are reserved for about an hour. This is so we can thoroughly evaluate your child's concerns and talk with you about real cures. We dedicate our time with you for a full understanding of your condition and concerns.

We also compound on-site, custom remedies and homeopathic treatments that are tailored to each individual patient. Further, we have on-site therapeutic treatment capabilities

Because we operate entirely different from the typical medical office, we have found most insurance programs do not adequately compensate us for the time we take with all our patients. Consequently, we do not bill insurance plans. Some insurance plans may reimburse you for our care. It is up to you to submit our bill to your insurance carrier if you so choose***. In any event, complete payment for our services is due on the date of your child's visit.***

Here is a brief example of our typical office fees:

Typical first office visit includes: 2 one hour visits that fully evaluate food intolerance, Bolen blood analysis, Iris diagnosis, Acoustic Cardiograph, and a full case history followed by a 1 hour report of findings and plan of treatment.	$ 450.00
General returning patient office visit (1hr); (with venipuncture, Bolen blood analysis recheck and ACG add $80.00).	$ 175.00
Hyperbaric Oxygen Therapy (1hr)	$ 155.00
Constitutional Hydrotherapy Treatments (1hr)	$95.00/or decrease package prices
Compounded therapeutic treatment remedies and / or supplements	$ varies

*Fees for medical services not listed are available upon request. Laboratory fees are not included in above fee schedule.

Cancellation Policy: Patients will be billed for any appointment cancelled with less than 24 hours notice. There is a $125.00 missed appointment fee.

I understand that I am wholly and personally responsible for ***payment on date of service***. The Windrose Naturopathic Clinic is not a participant in Medicare or insurance plans. I realize that I may request the attending physician's statement of diagnosis and services provided to me, which I may submit to my insurance company for reimbursement of the treatment cost, as may be provided by my plan. The Windrose Naturopathic Clinic does not guarantee that I will receive reimbursement from my insurance carrier. I understand that Windrose Naturopathic Clinic, at it's option, may charge me interest on any unpaid balances.

I have read and agree to the financial terms and cancellation policy above:

Date	Parent's Signature	Social Security #