Windrose Naturopathic Clinic

Family Practice – Preventative Care

1023 W Francis Ave, Spokane WA 99205 (509) 327-5143 (509) 327-9813 (fax)

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? ____

YOUR CHILD'S HEALTH

Please tell us about your child's health concerns, history and family. Our health care and preventative medicine are only possible when we have a complete understanding of your child's physical, mental and emotional state.

First of all, does your child have any special needs? ❑ No ❑ Yes: ____

What goals / issues do you have for your child in coming to see us today: ____

____

If a "diagnosis" has been made by a previous doctor, please list below (with dates):

____

____

Does he / she have any known allergies? ❑ No ❑ Yes: ____

Please list any prescriptions, over-the-counter, homeopathics, supplements your child takes (list dosages):____________________________

____

____

Has your child had any major childhood illnesses, accidents, injuries, surgeries, hospitalizations, traumas, etc (dates and age at time): ________

____

How was the pregnancy and childbirth for mom? ______________________________

____

____

X-Rays & Special Studies: ☐ X-Rays ☐ CAT Scans ☐ MRI's When: ______________________________

____

How would you rate the general health of our child: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent) circle one

Does your child have any fears? ______________________________

____

What are your child's favorite foods and how often are they eaten? ______________________________

____

What types of pets do you own? ______________________________

____

What are some of your child's favorite activities / hobbies? ______________________________

____

Does anyone in the house smoke? ☐ No ☐ Yes

How many hours of TV / Computer / Video games does you child engage in daily? ______________________________

How would you rate your child's academic performance: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent) circle one

Is there anything else you would like to tell us about your child? ______________________________

____

MEDICATIONS, SUPPLEMENTS & OVER THE COUNTER DRUGS

Please list all of the over-the-counter drugs, prescription medications & supplements you take regularly: ______________________________

____

____

____

Continued on next page . . .

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		Covid

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:___________
Coffee: P C Freq: __________
Alcohol: P C Freq:___________

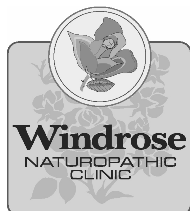
Tobacco: P C Type/Freq_________
Recreational Drugs: P C Type/Freq_________
Other: P C Type/Freq ________

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 diagnosis and treatment(s):

Common diagnostic procedures: including but not limited to general physical exams, PAP smears, 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 lab 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 your body's innate healing ability. We will always strive to provide full disclosure of all information relevant to your 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.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are 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	Patient 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 treat symptoms with drugs that simply mask your underlying causes. ***We DO treat the underlying causes of your illness***.

We practice medicine differently from the typical medical model. First of all, we take considerably more time with you. Most of our appointments are reserved for about an hour. This is so we can thoroughly evaluate your concerns and talk with you about your healing plan. 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 visit.***

Here is a brief example of our typical office fees:

Dr.Tish: Typical first office visit includes: 2 one hour visits that fully evaluate food intolerance, Iris diagnosis, Acoustic Cardiograph, and a full case history followed by a 1 hour report of findings and plan of treatment.	$ 550.00
Dr. Harrison: Typical first office visit includes: 2 one hour visits that fully evaluate food intolerance, 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); including ACG	$ 275.00
Bio-identical hormone evaluation (w/ added lab fees as necessary, varies depending on specific panels) and result consultation.	$ 145.00 (30 min.) $ 195.00 (60 min.)
Report of Digital Thermal Imaging and plan of therapy (60 minutes)	$ 195.00
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 | Patient Signature | Social Security

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Other Services		
Limited office visit (15 minutes)		$ 115.00
Intermediate office visit (30 minutes)		$ 145.00
Extended office visit (60 minutes)		$ 195.00
Comprehensive office visit (90 minutes)		$ 280.00
Phone Consult w/treatment Short (15 minutes)		$ 115.00
Phone Consult w/treatment Medium (30 minutes)		$ 145.00
Phone Consult w/treatment Long (60 minutes)		$ 195.00
Well Woman Exam w/Pap		$ 165.00
Vaginal Pack Therapy		$ 115.00
Acoustic Cardiograph		$ 80.00
Bowen Manipulation (1 hr)		$ 145.00
Acupuncture 1st visit (90 minutes)		$ 150.00
Acupuncture return visit (45-60 minutes)		$ 115.00
Acupuncture reevaluation visit (1 hr)		$ 135.00

Telehealth

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using information and communication technologies.

Telehealth uses health information for diagnosis, therapy, follow-up and/or education, and may include any of the following:

❍ Patient medical records
❍ Medical images
❍ Live two-way audio and video
❍ Output data from medical devices and sound and video files

During the Telehealth health service, details of your medical history, examinations, x-rays, and tests may be discussed using interactive video, audio and/or telecommunications technology.

All existing laws regarding privacy and security of your health information and copies of your medical records apply to this Telehealth health service and the audio and video information transmitted.

Windrose Clinic will do our best to protect the confidentiality of the patient identification and imaging data.

Initials ______________