willamette integrative health

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THIS FORM IS DUE AT LEAST 24 HOURS BEFORE THE FIRST APPOINTMENT.

PEDIATRIC PATIENT INFORMATION

Patient name	last	first	middle initial
Date of birth	**Age**	**Sex**	**Grade in school**
Mailing address			
City, State, Zip		**Social security #**	
Race ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White		**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino	

ADDITIONAL CONTACT INFORMATION

Mother	Name (first and last):	Best phone number:
	Address: ☐ same as child	
Father	Name (first and last):	Best phone number:
	Address: ☐ same as child	

Are all parents aware that child will be a patient here? ☐ YES ☐ NO

Emergency contact:	relationship	phone

INSURANCE INFORMATION

☐ **I will pay in full at time of service.** ☐ **Please bill my insurance. I have verified my benefits and I will present my card.**

ASSIGNMENT OF BENEFITS (FOR INSURANCE BILLING) **initials** _____

I hereby authorize Willamette Integrative Health to submit claims to my insurance carrier for all services rendered. I authorize the release of any medical information necessary to process these claims. I direct third party payers to issue payment directly to Willamette Integrative Health, LLC. I understand that it is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the medical services received.

Name of insured		Sex	Relationship to patient
DOB	SSN	Insured's address – if different from patient	
Member ID #	Group #		
Insurance company		insurance phone	
Copay	Deductible	Amount met	Reset date

CONDITIONS OF PATIENT REGISTRATION

MEDICAL CONSENT **initials** _____

I consent to the provision of health care services for my child at Willamette Integrative Health and request the health care provider(s) to provide any care they think is necessary and consistent with my instructions. I understand this care may include examinations, labs, imaging, and medical or surgical treatments. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care. If the health services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by the provider(s) during each visit.

FINANCIAL POLICY **initials** _____

I have been offered a copy of the Financial Policy and I have reviewed and agree to the policy. I agree to promptly pay all fees and charges for treatment provided to me and/or my family. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. If I disagree with any charges I will contact WIH within 30 days of billing.

HIPAA PRIVACY POLICY **initials** _____

I have been offered a copy of the Notice of Privacy Practices and I have reviewed and agree to the policy.

I have read and fully understand all of the information above as conditions of my registration.

_______________________________ _______________________________ ____________

name of parent or guardian (please print) **signature** of parent or guardian **date**

CONTEXT OF CARE	
pediatrician or primary care doctor	
other doctors or practitioners	
preferred pharmacy	**preferred hospital**

We are so glad to welcome you to Willamette Integrative Health! Why did you choose to seek care with us?

____

Please list the top 3 biggest concerns for the health of this child.

1. ____
2. ____
3. ____

What are your expectations for the first visit? ______________________________________

What are your expectations for our work together in general? _______________________________

What is your level of commitment to achieving these goals? _______________________________

MEDICATIONS AND ALLERGIES				
name of medication or supplement	**dose and frequency**	**reason for taking**	**date started**	**prescribed by**

(if this space is not sufficient, please attach extra pages).

allergy	**reaction**	**severity**

PAST MEDICAL HISTORY

Vaccination status (please attach records): ☐ CDC schedule, up to date ☐ alternate schedule ☐ have questions

Past major illnesses or injuries: ____

Surgeries or hospitalizations (include year): ______________________________________

PRENATAL AND BIRTH HISTORY			
Mother's age at child's birth:	Previous # of pregnancies: live births: miscarriages: abortions:		
Mother's health during pregnancy: ☐ nausea ☐ bleeding ☐ STI ☐ illness or infection ☐ trauma or injury ☐ toxemia ☐ hypertension ☐ pre-eclampsia ☐ eclampsia ☐ gestational diabetes ☐ pre-existing diabetes			
Delivery: ☐ full term (39-40 weeks) ☐ other (# wks gestation):	length of labor:	☐ pitocin used?	
☐ vaginal birth ☐ C-section	☐ complications or birth injuries?	birth weight: length:	

INFANCY AND CHILDHOOD DEVELOPMENT	
If breastfed: ☐ nursing ☐ bottle Duration:	Any feeding difficulty during first months? ☐ YES ☐ NO
If formula fed: ☐ dairy ☐ soy ☐ other: Duration: Brand:	
Age at first solid food:	What were first foods introduced?
Age began crawling: walking: talking:	☐ concerns with speech, hearing, vision, reading ability?
Toilet training: ☐ day bladder ☐ day bowel ☐ night bladder ☐ night bowel ☐ loss of previous toilet training	

FAMILY HISTORY

Please list age, whether living or deceased, and any major health issues (including cause of death, if known)

Mother ____

Maternal grandmother ____

Maternal grandfather ____

Father ____

Paternal grandmother ____

Paternal grandfather ____

Sister(s) ____

Brother(s) ____

Other ____

SOCIAL HISTORY

How would you describe your child's personality? ______________________________

Has s/he experienced major stressors such as moves or losses? ______________________________

What is your family's religious affiliation? How does this affect health decisions? ______________________________

Do you feel your child learns more quickly, on average, or more slowly than others? ______________________________

Behavioral concerns? ☐ lack of social skills or interests ☐ anxiety/depression ☐ ritual behaviors ☐ eye contact
☐ attention span ☐ emotional reactions (aggression/anger/mood swings) ☐ response to sound/light/touch
☐ other: ____

diet and exercise

Are you satisfied with the way the child eats? ☐ YES ☐ NO Why? ______________________________

Are you able and willing to make potentially major dietary changes for this child's health, if necessary? ☐ YES ☐ NO

Appetite: ☐ high ☐ moderate ☐ low Food cravings? ______________________________

Thirst: ☐ high ☐ moderate ☐ low Food restrictions? ______________________________

Food coloring, sugar, preservatives, and processed foods in diet: ☐ high amount ☐ moderate amount ☐ low amount

Typical breakfast: ____

Typical lunch: ____

Typical dinner: ____

Snacks: ____

Beverages: ____

Exercise and fitness: ____

Favorite toys, activities, hobbies: ____

sleep and energy

Average # of hours sleep per night:	# of naps:	Where does the child sleep?
Any recurring dreams or nightmares? If so, what is the theme?		
Average energy level throughout the day: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = highest		
Best energy time of day:	Worst energy time of day:	

home and travel	
Water source: ☐ plain tap ☐ filtered tap ☐ distilled ☐ bottled ☐ well water ☐ other:	
Food prep and storage: ☐ microwave ☐ non-stick pots and pans ☐ aluminum pans ☐ plastic storage containers	
Home and work well ventilated? ☐ YES ☐ NO	Does home or work have known mold issues? ☐ YES ☐ NO

Are you aware of any toxic exposures? ______________________________

How many hours of "screen time" does the child have each day (TV, computer, video games, devices): __________

Has the child traveled outside the US? When and where? ______________________________

REVIEW OF SYSTEMS

Y = yes, current issue P = issue in the past N = never had this problem

GENERAL

height ____________________

weight ____________________

blood type ____________________

SKIN			
acne	☐ Y	☐ P	☐ N
eczema or rashes	☐ Y	☐ P	☐ N
itching or hives	☐ Y	☐ P	☐ N
moles or lesions	☐ Y	☐ P	☐ N

HEAD			
tension headaches	☐ Y	☐ P	☐ N
migraines	☐ Y	☐ P	☐ N
head injury	☐ Y	☐ P	☐ N
sensitivity to light	☐ Y	☐ P	☐ N

EYES

last eye exam ____________________

crossed eyes	☐ Y	☐ P	☐ N
double vision	☐ Y	☐ P	☐ N
eye pain	☐ Y	☐ P	☐ N
dry eyes	☐ Y	☐ P	☐ N

EARS			
impaired hearing	☐ Y	☐ P	☐ N
ringing (tinnitus)	☐ Y	☐ P	☐ N
ear pain	☐ Y	☐ P	☐ N
frequent infections	☐ Y	☐ P	☐ N

NOSE AND SINUSES			
hay fever	☐ Y	☐ P	☐ N
congestion	☐ Y	☐ P	☐ N
nosebleeds	☐ Y	☐ P	☐ N
sinus infection	☐ Y	☐ P	☐ N
frequent colds	☐ Y	☐ P	☐ N

MOUTH AND THROAT

last dental exam ____________________

cavities	☐ Y	☐ P	☐ N
gum disease	☐ Y	☐ P	☐ N
mouth/tongue pain	☐ Y	☐ P	☐ N
sore throat	☐ Y	☐ P	☐ N
hoarseness	☐ Y	☐ P	☐ N
difficulty swallowing	☐ Y	☐ P	☐ N

NECK			
pain or stiffness	☐ Y	☐ P	☐ N
swollen glands	☐ Y	☐ P	☐ N
chronic large tonsils	☐ Y	☐ P	☐ N

RESPIRATORY			
cough	☐ Y	☐ P	☐ N
wheezing	☐ Y	☐ P	☐ N
shortness of breath	☐ Y	☐ P	☐ N
asthma	☐ Y	☐ P	☐ N
pneumonia	☐ Y	☐ P	☐ N

CARDIOVASCULAR

last EKG ____________________

heart murmur	☐ Y	☐ P	☐ N
heart defect	☐ Y	☐ P	☐ N
heart palpitations	☐ Y	☐ P	☐ N
high blood pressure	☐ Y	☐ P	☐ N
anemia	☐ Y	☐ P	☐ N
easy bruising	☐ Y	☐ P	☐ N
blood clots	☐ Y	☐ P	☐ N

ENDOCRINE			
heat/cold intolerance	☐ Y	☐ P	☐ N
hyper/hypo thyroid	☐ Y	☐ P	☐ N
diabetes	☐ Y	☐ P	☐ N
signs of early puberty	☐ Y	☐ P	☐ N

GASTROINTESTINAL			
abdominal pain	☐ Y	☐ P	☐ N
nausea or vomiting	☐ Y	☐ P	☐ N
heartburn/reflux	☐ Y	☐ P	☐ N
gas or bloating	☐ Y	☐ P	☐ N
constipation	☐ Y	☐ P	☐ N
diarrhea	☐ Y	☐ P	☐ N
blood in stool	☐ Y	☐ P	☐ N

bowel movements per day __________

URINARY

urinations/wet diapers per day _______

pain with urination	☐ Y	☐ P	☐ N
frequency	☐ Y	☐ P	☐ N
urgency	☐ Y	☐ P	☐ N
bed wetting	☐ Y	☐ P	☐ N
other incontinence	☐ Y	☐ P	☐ N
bladder infections	☐ Y	☐ P	☐ N
kidney stones	☐ Y	☐ P	☐ N
dark urine	☐ Y	☐ P	☐ N

MUSCULOSKELETAL			
scoliosis	☐ Y	☐ P	☐ N
joint pain/stiffness	☐ Y	☐ P	☐ N
muscle pain/spasm	☐ Y	☐ P	☐ N
muscle weakness	☐ Y	☐ P	☐ N

NEUROLOGICAL			
stroke	☐ Y	☐ P	☐ N
seizures	☐ Y	☐ P	☐ N
tremor	☐ Y	☐ P	☐ N
numbness/tingling	☐ Y	☐ P	☐ N
loss of taste/smell	☐ Y	☐ P	☐ N
loss of balance	☐ Y	☐ P	☐ N
loss of memory	☐ Y	☐ P	☐ N
dizziness/fainting	☐ Y	☐ P	☐ N

Is there anything else you think we should know about this child before the first visit? ____________________

____

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Thank you! We appreciate your time and attention to detail, and look forward to meeting your child.