

Kelley R. Reis

503-693-0904

The Natural Medicine Center

172 SE 6th Ave

Hillsboro, OR 97123

PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name: _____ Date of first visit: _____

Age: _____ Date of Birth: ____/____/____ Gender: female _____ male _____

Mother's name: _____ Father's name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone # (home): (____) _____ Parents # (work): (____) _____

Parents e-mail address: _____

How did you hear about Dr. Reis? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____

Reason for referral or presenting problems: _____

Table with columns for Medications (Now, Past) and Allergies to medicines.

MEDICAL HISTORY

Chicken pox, Measles, Mumps, Rubella, Scarlet fever, Pneumonia, Frequent colds, Rheumatic fever, Tonsillitis, Ear infections, other (please list)

Has your child had any of the following tests? When Where Results Electroencephalogram Psychological evaluation Hearing Speech/Language

Injuries/Surgeries/Hospitalizations (please list): _____

IMMUNIZATIONS

Measles, Mumps, Polio, DPT, MMR, Tetanus, Smallpox, Influenza, Diphtheria

Any adverse reactions? Y N What? _____

FAMILY HISTORY

Heart disease, Hypertension, Cancer, Diabetes, Arthritis, Allergies, Birth defects, Tuberculosis, Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth? _____

Mother's health during pregnancy?

- | | |
|--------------------|---|
| _____ Bleeding | _____ Physical or emotional trauma |
| _____ Nausea | _____ Cigarettes, alcohol, drug consumption |
| _____ Illnesses | _____ Medications |
| _____ Hypertension | _____ Thyroid problems |
| | _____ Diabetes |

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

- | | | |
|----------------------|----------------------|-----------------|
| _____ Birth defects | _____ Birth injuries | _____ Blue baby |
| _____ Cerebral palsy | _____ Seizures | _____ Jaundice |
| _____ Colic | _____ Fever | _____ Rashes |

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

- | | | |
|----------------------|--------------------------|---------------------------|
| _____ Hives | _____ Burning of urine | _____ Bloody urine |
| _____ Eczema | _____ Frequent urination | _____ Cries easily |
| _____ Bleeding gums | _____ Heart murmur | _____ Nervous |
| _____ Nose bleeds | _____ Vomiting spells | _____ Sleep problems |
| _____ Acne | _____ Anemia | _____ Night sweats |
| _____ High fevers | _____ Stomach aches | _____ Sensitive to light |
| _____ Chronic rash | _____ Jaundice | _____ Body/breath odor |
| _____ Hearing loss | _____ Easy bruising | _____ Motion/car sickness |
| _____ Diarrhea | _____ Flat feet | _____ No appetite |
| _____ Sore throats | _____ Constipation | _____ Nightmares |
| _____ Headaches | _____ Gas | _____ Canker sores |
| _____ Frequent colds | _____ Bleeding tendency | _____ Unusual fears |
| _____ Wheezing | _____ Joint pains | _____ Excessive fatigue |
| _____ Cough | _____ Dizzy spells | _____ Hair loss |

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. I look forward to helping your child in any way I can.

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Dear New Patient,
Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

Initials **Payment for all services and dispensary items is due at the time of the visit.**

Initials **We are not providers on all insurance plans, therefore you may be required to bill your own insurance. We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.**

Initials **You will be charged a Missed Appointment fee for any missed appointments or late cancellations (less than 24 hours notice).**

Initials **I give permission for the staff at The Natural Medicine Center to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$25.00 for every returned check(s). We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care providers who may be providing similar services at The Natural Medicine Center. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at The Natural Medicine Center.

Your health care provider may prescribe medication, which may be purchased either at The Natural Medicine Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Your Signature (parent signature if minor)

Print your name (parent name if minor & patient name)

Date