

Hello and Welcome!

Attached you will find pediatric intake forms. Before your child's scheduled appointment, please fill out the forms as thoroughly as possible. I know your time is valuable and by bringing your already completed intake forms with you will maximize the time spent at your health visit.

Your child's first visit will consist of a thorough assessment of his/her health history lasting between 45 minutes to an hour. Please bring copies of any recent lab work, as well as any supplements or medications your child is currently taking.

If you are unable to keep your child's scheduled appointment for any reason, please let us know so we can reschedule his/her visit at a more convenient time. A 24-hour notice is greatly appreciated.

I truly look forward to working with you and your child on the journey towards optimal health.

Warmly,  
Amanda H. Fey, ND

Amanda H. Fey, ND The Center  
1 Hoffman St, Suite B Auburn, NY 13021 Ph. (315) 704-0319

**NEW PEDIATRIC INTAKE FORM (0-12 years old)**

Date\_\_\_\_\_ Child's name\_\_\_\_\_

Date of Birth\_\_\_\_\_ Age\_\_\_\_\_ Gender: Male or Female

Address:\_\_\_\_\_

STREET OR PO BOX

CITY, STATE, ZIP

Phone: Home\_\_\_\_\_ Work/Cell\_\_\_\_\_

Mother's Name:\_\_\_\_\_ Father's Name: \_\_\_\_\_

If parents are separated, child primarily lives with:\_\_\_\_\_

Emergency contact-name, phone, relationship  
\_\_\_\_\_

How did you hear about our clinic?\_\_\_\_\_

**HEALTH HISTORY**

What are your child's most important health concerns? List them in order of importance

1. \_\_\_\_\_ Date of Onset\_\_\_\_\_
2. \_\_\_\_\_ Date of Onset\_\_\_\_\_
3. \_\_\_\_\_ Date of Onset\_\_\_\_\_
4. \_\_\_\_\_ Date of Onset\_\_\_\_\_
5. \_\_\_\_\_ Date of Onset\_\_\_\_\_

Is your child currently receiving healthcare for his/her concerns?  Yes  No

If yes, where and from whom?\_\_\_\_\_

If no, when and where did you last receive medical or health care? What was the reason?  
\_\_\_\_\_

<u>Previous Hospitalizations/Surgeries</u>	<u>Reason</u>	<u>Date</u>

How would you describe your child's overall state of health (please circle)?

Excellent      Good      Average      Fair      Poor

**PREVIOUS ILLNESSES**

Measles	Y	N	Rheumatic Fever	Y	N
Chicken Pox	Y	N	Rubella	Y	N
Mononucleosis	Y	N	Tonsillitis	Y	N
Mumps	Y	N	Ear Infections	Y	N
Pneumonia	Y	N	Seizures	Y	N

**ALLERGIES**

Does your child have any allergies to drugs, food, or to the environment (animals, dust, mold, etc)  No  Yes

If yes, please indicate what allergies and how he/she was tested

\_\_\_\_\_

**VACCINATIONS**

- Diphtheria       Measles/Mumps/Rubella       Pertussis       Chicken Pox
- Tetanus       Hepatitis B       Polio       Pneumococcal
- HiB       Influenza       Other\_\_\_\_\_

**TYPICAL FOOD INTAKE**

Breakfast:\_\_\_\_\_

Lunch:\_\_\_\_\_

Dinner:\_\_\_\_\_

Snacks:\_\_\_\_\_

Beverages:\_\_\_\_\_

Breast fed?\_\_\_\_\_ How long?\_\_\_\_\_ Formula (type)?\_\_\_\_\_

Were there any trouble introducing foods as infant? If yes, which foods and what were the difficulties?\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS**

Please list all current prescription medications and over the counter medications:

1. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
2. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
3. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
4. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_

How many courses of antibiotics has your child had in the past 10 years?\_\_\_\_\_

**CURRENT SUPPLEMENTS**

Please list all current supplements including herbs, vitamins, and/or other supplements:

1. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
2. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
3. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_
4. \_\_\_\_\_ Dose\_\_\_\_\_ Indication\_\_\_\_\_

**FAMILY HISTORY**

Please indicate if any family member has/had any of the following:

	Family member		Family member
Cancer	_____	Autoimmune Disease	_____
Heart Disease	_____	Asthma/Allergies	_____
Diabetes	_____	Alcoholism/Addictions	_____
Tuberculosis	_____	Birth Defects	_____
Depression/Anxiety	_____	Hypertension	_____
Mental Illness	_____	Bleeding disorders	_____

**REVIEW OF SYSTEMS**

		N = Now		P = Past	
<b>MENTAL/EMOTIONAL</b>					
Irritability	N	P	Mood swings	N	P
Anxiety/nervousness	N	P	Hyperactive	N	P
Poor concentration	N	P	Unusual fears	N	P
Sleep problems	N	P	Nightmares	N	P
Cries easily	N	P	Introvert/Extrovert	_____	
<b>SKIN</b>					
Rashes	N	P	Acne or Boils	N	P
Itching	N	P	Eczema/Hives	N	P
<b>HEAD</b>					
Headaches	N	P	Dizzy spells	N	P
Head Injury	N	P	High Fevers	N	P
<b>EYES</b>					
Glasses or contacts	N	P	Tearing or dryness	N	P
Eye pain/strain	N	P			
<b>EARS</b>					
Impaired hearing	N	P	Earaches	N	P
<b>NOSE &amp; SINUSES</b>					
Frequent Colds	N	P	Nose Bleeds	N	P
Hay fever	N	P	Stuffiness	N	P
Sinus Problems	N	P	Loss of Smell	N	P
<b>MOUTH &amp; THROAT</b>					
Frequent sore throat	N	P	Canker sores	N	P
Bleeding gums	N	P	Breath odor	N	P
<b>RESPIRATORY</b>					
Cough	N	P	Asthma	N	P
Wheezing	N	P	Bronchitis	N	P

		N = Now		P = Past	
<b>CARDIOVASCULAR</b>					
Heart Disease	N	P	Murmurs	N	P
<b>GASTROINTESTINAL</b>					
Diarrhea	N	P	Constipation	N	P
Belching/ Gas	N	P	Stomachaches	N	P
Bowel Movements:	How many/day? _____		Is this a change? _____		
<b>URINARY</b>					
Frequent urination	N	P	Kidney stones	N	P
Frequent infections	N	P	Bed wetting	N	P
<b>MUSCULOSKELETAL</b>					
Joint pain/stiffness	N	P	Muscle spasm/cramps	N	P
Broken bones	N	P			
<b>BLOOD/PERIPHERAL VASCULAR</b>					
Easy bruising/ bleeding	N	P	Anemia history	N	P
<b>ENDOCRINE</b>					
Heat/ cold intolerance	N	P	Low blood sugar	N	P
Excessive thirst	N	P	Excessive hunger	N	P
Fatigue	N	P	High blood sugar	N	P

Is there any information about your child's health that you would like to add?

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THANK YOU FOR TAKING THE TIME TO ANSWER THE ABOVE QUESTIONS!

I certify that the information that I have given above is correct and accurate to the best of my knowledge.

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Print name here \_\_\_\_\_

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<b>ADULT</b>	
FIRST HEALTH VISIT (usually 90 minutes)	\$140
RETURN HEALTH VISITS:	
30 minutes	\$70
45 minutes	\$95
60 minutes	\$125
ACUTE HEALTH VISIT (30 minutes)	\$70
<b>PEDIATRICS (0-12 years old)</b>	
FIRST HEALTH VISIT:	
45 minutes	\$105
60 minutes	\$125
RETURN HEALTH VISITS:	
20 minutes	\$50
30 minutes	\$70
45 minutes	\$95
ACUTE/WELLNESS VISITS (30 minutes)	\$70
ACUTE RETURN VISITS (20 minutes)	\$50
<b>PHONE CONSULTATIONS</b>	
Hourly rate is \$100, billed in 15 minute increments.	
To clarify simple questions (post visit)	No charge
<b>PROGRAMS</b>	
DETOXIFICATION	\$200
NUTRITION/SUPPLEMENT CONSULTS (30 minutes)	\$70
For each additional 15 minutes	\$30

**Payment Policy Agreement**

By signing below, you understand that full payment for all services and products you receive from Amanda H. Fey, ND is required at the time of service. MasterCard, VISA, Debit cards, checks, and cash are accepted. You understand that there will be a \$20.00 charge for each returned check. You understand that you will be charged a fee of \$50 for any missed appointments or any cancellations less than 24 hours ahead of your scheduled visit.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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**Consent Form and Agreement**

By signing below, you recognize and understand that Amanda H. Fey, ND is a Doctor of Naturopathic Medicine licensed in the state of Oregon; and therefore, is not licensed to practice medicine in the state of New York. Further, you recognize and understand that she does not diagnose, write, or change pharmaceutical prescriptions. Nutrition and natural health services do not replace the role of a conventional physician. Amanda H. Fey, ND is using her education and experience to give you suggestions about your health. You assume the responsibility for the decision to use a natural remedy. If you feel that you are experiencing any adverse reactions then you understand to stop all supplements immediately.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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**Notice of Privacy Practices**

By signing below, you give permission to the staff at The Center to contact you by telephone and they may leave a message that may contain appointment or medical information if you are not available. You understand that you have the right to inspect and/or copy my health information. Requests to disclose your health information to another health care provider should be provided in writing, unless it is an emergency situation.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_