CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Pediatric Intake Form

Full Legal Name ____

Last Name First Name Middle Initial

Address ____

Street/PO Box City State Zip Code

Telephone ____

Home Work Cell Phone

E-mail address ____

Emergency Contact ____

Name Telephone Relationship

Date of Birth ______________ Age______ Female _____ Male _____

Mother's name ___________________________ Father's name ____________________________

Are parents Single _____ Married _____ Divorced _____ Other _______

Is there a number you prefer me **NOT** to leave a message? ____________________________________

Who is the child pediatrician?

____

Doctor's Name Name of Practice Telephone if Known

For what concern did your child last receive health or medical care?

____

MAIN CONCERNS

What are the most important health concerns for your child?

1. ____ Date of onset _______________
2. ____ Date of onset _______________
3. ____ Date of onset _______________
4. ____ Date of onset _______________

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PRENATAL HISTORY

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

Mother's age at child's birth ? __________

Mother's health during pregnancy?

____ Bleeding ____ Illnesses

____ Nausea ____ Hypertension

____ Diabetes ____ Physical or emotional trauma

____ Thyroid problems ____ Cigarettes, alcohol, drug consumption

____ Medications:____

BIRTH HISTORY

Weight at birth _________________

Length at birth__________________

Term ____ Full ____ Premature ____ Late How long?____

Birth ____ Induced ____ Vaginal ____ C-Section ____ V-Bac

Length of labor _______________________ Complications? ____

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

____ Birth defects ____ Brain injuries ____ Blue baby

____ Cerebral palsy ____ Seizures ____ Jaundice

____ Colic ____ Fever ____ Rashes

Other ____

MEDICAL HISTORY

____ Chicken Pox ____ Scarlet fever ____Tonsillitis, approx. no. __________

____ Measles ____ Pneumonia ____ Ear Infections, approx no._______

____ Mumps ____ Frequent colds ____ Rubella

____ Rheumatic Fever ____ Other ____

Has your child had any of the following tests?

____ Electroencephalogram Date_____________

____ Psychological evaluation Date_____________

____ Hearing Date_____________

____ Speech/Language Date_____________

____ Injuries/Surgeries/Hospitalizations Date_____________

Please explain____

CHILD DEVELOPMENT

Age began Sitting ________ Crawling _________ Walking _________ Talking _________

Child's sleep patterns (first year) ____

Food intolerances ____

Feeding ____ Breast fed How long ___________________

____ Formula Milk/soy/other _______________

Age began solids ______________ Which foods? ____

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FAMILY HISTORY

	Father	Mother	Brother	Sister	Children	Maternal GParent	Paternal GParent
Age if Living							
Current Health							
Age at Death							
Cause of Death							

Indicate if there have been any of the following diseases in the child's family:

___ Cancer ___ Diabetes ___ Epilepsy ___ Heart Disease
___ Stroke ___ Epilepsy ___ Anemia ___ Allergies
___ Kidney Disease ___ Asthma ___ Mental Illness ___ Glaucoma
___ Arthritis ___Alzheimer's Dz ___ High Blood Pressure

IMMUNIZATIONS

____ Measles ____ Polio ____ MMR ____ Smallpox
____ Mumps ____ DTaP ____ Tetanus booster ____ Influenza
____ Pertussis ____ Chickenpox ____ Hib ____ HPV
____ Meningococcal ____ Flu ____ Hep A ____ Hep B
____ Rotovirus ____

Other ____

Any adverse reactions ____

ALLERGIES

Is your child hypersensitive or allergic? ____ Yes ____ No

List food triggers____

List environmental triggers ____

MEDICATIONS

Check medications (prescribed or over the counter), your child has taken or is presently taking.

___Aspirin ___Antibiotics ___ Anti-epileptic
___Tylenol ___Anti-histamine ___Decongestant
___Ibuprofen ___Other (Please list)______________________________________

___Allergies to medicines (Please list) ______________________________________

SUPPLEMENTS

List herbs, vitamins, supplements, etc. that your child is currently taking.

1. ____________________ Dose________ 4. ____________________ Dose________
2. ____________________ Dose________ 5. ____________________ Dose________
3. ____________________ Dose________ 6. ____________________ Dose________

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SYMPTOMS

Check any of the following your child has or has had in the past.

___Acne	___Anemia	___Anxiety	___Asthma
___Bedwetting	___Belching	___Bleeding gums	___Bleeding tendency
___Bloody urine	___Body/ breath odor	___Bronchitis	___Burning with urination
___Canker sores	___Chronic rash	___Constipation	___Cough
___Cries easily	___Diarrhea	___Diarrhea	___Dizzy spells
___Earaches	___Easy bruising	___Eczema	___Excessive fatigue
___Excessive hunger	___Excessive thirst	___Eye dryness	___Eye pain
___Fatigue	___Flat feet	___Frequent colds	___Frequent sore throat
___Frequent urination	___Gas	___Hair loss	___Hay fever
___Head injury	___Headaches	___Hearing loss	___Heart disease
___Heart murmur	___Heat/Cold intolerances	___High blood sugar	___High fevers
___Hives	___Hyperactivity	___Impaired hearing	___Irritability
___Itching	___Jaundice	___Joint pains	___Low blood sugar
___Mood swings	___Motion/car sick	___Muscle spasms	___Nervous
___Night sweats	___Nightmares	___No appetite	___Nose bleeds
___Sensitive to light	___Sinus problems	___Sleep problems	___Sore throats
___Stomach aches	___Stomach aches	___Stuffiness	___Unusual fears
___Vomiting spells	___Wheezing		

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By signing below, I verify that the above information is correct and true to the best of my knowledge.

Patient Name (Please print)____________________ Patient Signature __________________

Legal Guardian Signature_____________________ Today's Date ___________________

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CONSENT TO TREATMENT A MINOR

I, _____________________, am parent and/or legal guardian of _______________, hereby give

Parent's Name Child's Name

permission to Ileana Tecchio ND, LAc, to treat my child.

Signature ___________________ Relationship to Child________________ Date___________

NOTICE OF PRIVATE PRACTICES

PATIENT RIGHTS

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to New Leaf Holistic Health. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact New Leaf Holistic Health. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to New Leaf Holistic Health and we will respond to you within 30 days of receipt of your written request.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to New Leaf Holistic Health. We will respond within 30 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 30 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Ne Leaf Holistic Health to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print)_________________________ Patient Signature _______________________

Legal Guardian Signature__________________________ Today's Date _______________________

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

NEW LEAF HOLISTIC HEALTH FINANCIAL POLICIES

Unless prior arrangement is made, full payment is appreciated at the time of service.

- Your payment options are: cash, check, or credit/debit cards.
- We accept Visa, MasterCard, and Discover

Insurance Billing

- If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
- You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
- Insurance companies may reimburse differently than the information they initially provide to us.
- **You are responsible for and will be billed for any resulting unpaid balance.**

Past Due Accounts

- **Accounts greater than 30 days past due will be charge a $5.00/ month administrative fee.**
- **Accounts greater than 90 days overdue will be sent to a collections agency.**

Below is our Fee Schedule

- New Patient

Initial Naturopathic Consultation 90 Min	175.00
Focused Naturopathic Consultation 55 Min	105.00
Acute Naturopathic Consultation 35 Min	75.00

- Established Patient

Follow Up Visit 55 Min	75.00
Focused Follow Up Visit 35 Min	55.00
Brief Follow Up Visit 25 Min	45.00

- Acupuncture

Acupuncture or Cupping 55 Min	75.00
Three Acupuncture or Cupping Visits	195.00

- Therapeutic Massage

Sixty Minutes Massage	75.00
Ninety Minutes Massage	100.00

- Hydrotherapy

Single Hydrotherapy	85.00
Three Hydrotherapy	225.00

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I have read, understood and agree to the policies described above.

Patient Name (Please print)________________________ Patient Signature ______________________

Legal Guardian Signature_________________________ Today's Date ______________________

INFORMED CONSENT

GLENN FINLEY N.D.

Glenn Finley N.D. is licensed to practice Naturopathic Medicine in the state of Vermont. Glenn Finley N.D. has a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. He is a member of the American Association of Naturopathic Physicians. Glenn Finley N.D. does not provide after hour services and in case of an emergency I understand I should contact the appropriate licensed health care provider.

Naturopathic Medicine in the state of New York

A Naturopathic Doctor is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. **Currently licensure for Naturopathic Doctors is not available in the state of New York**. Therefore, Glenn Finley N.D. does not practice medicine, and does not diagnose or treat diseases, or medical conditions in the state of New York. In the state of New York, Glenn Finley N.D. focuses his practice on the enhancement of health. The services he provides are not meant to substitute or replace those of a licensed physician. Patients seeking his consultation are advised to also be under the care of a licensed New York state physician.

Naturopathic Medicine in the State of Vermont

As a Naturopathic Doctor in the state of Vermont, Glenn Finley N.D. is licensed to practice as a primary health care provider and is a board-certified physician.

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I herby request and consent to a naturopathic consultation, herbal and nutritional supplement suggestions for me (or for the patient named below, for which I am legally responsible) by Glenn Finley N.D.

I understand that all my records will be kept confidential and will not be released without my written consent. I understand it may be necessary for Glenn Finley N.D. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Glenn Finely N.D. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any suggestions given by Glenn Finley N.D. I have read, or have had read to me, the above consent. I intend this consent form to cover all the suggestions Glenn Finley N.D. will provide me for my present condition and for any future condition(s) for which I seek assistance with. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above.

Patient Name ________________________ Patient Signature ________________________

Legal Guardian ________________________ Today's Date ________________________