

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.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alzheimer's Dz | <input type="checkbox"/> High Blood Pressure | |

IMMUNIZATIONS

- | | | | |
|--|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> MMR | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> DTaP | <input type="checkbox"/> Tetanus booster | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Pertussis | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Hib | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Flu | <input type="checkbox"/> Hep A | <input type="checkbox"/> Hep B |
| <input type="checkbox"/> Rotovirus | <input type="checkbox"/> | | |

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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Anti-epileptic |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Anti-histamine | <input type="checkbox"/> Decongestant |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Other (Please list) _____ | |
| <input type="checkbox"/> 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.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Belching | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Body/ breath odor | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Burning with urination |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizzy spells |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Eczema | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Eye dryness | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Flat feet | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent sore throat |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Gas | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heat/Cold intolerances | <input type="checkbox"/> High blood sugar | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Motion/car sick | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Nightmares | <input type="checkbox"/> No appetite | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Stuffiness | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Wheezing | | |

.....

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 _____

.....

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

ILEANA TECCHIO N.D., L.Ac., Dipl.Ac., M.S.O.M.

Ileana Tecchio N.D., L.Ac. is licensed to practice acupuncture by the state of New York. Ileana Tecchio N.D., L.Ac. is licensed to practice Naturopathic Medicine by the state of Vermont. She is Board Certified in Oriental Medicine by the National Certification Commission for Colleges of Acupuncture and Oriental Medicine (NCCAOM). Ileana Tecchio N.D., L.Ac. has a Master degree in the Science of Oriental Medicine and a Doctorate degree in Naturopathic Medicine from the National College of Natural Medicine. She is a member of the American Association of Naturopathic Physicians. Ileana Tecchio N.D., L.Ac. use disposable-sterilized needles. She has passed the "Clean Needle Technique" examination of the Council of College of Acupuncture and Oriental Medicine (CCAOM). Ileana Tecchio N.D., L.Ac. 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. **However, currently licensure for Naturopathic Doctors is not available in the state of New York.** Therefore, Ileana Tecchio N.D., L.Ac. 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 Ileana Tecchio N.D., L.Ac. focuses her practice on the enhancement of health. The services Ileana Tecchio N.D., L.Ac. provides are not meant to substitute or replace those of a licensed physician. Patients seeking her 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, Ileana Tecchio N.D., L.Ac. is licensed to practice as a primary health care provider and as a board-certified physician.

.....

I hereby request and consent to acupuncture, herbal treatments and other procedures associated with Oriental Medicine on me (or on the patient named below, for which I am legally responsible) by Ileana Tecchio N.D., L.Ac. I understand that methods of treatments may include, but are not limited to:

- **Acupuncture** – whereby special sterilized fine needles are inserted through the skin into the underlying tissues and muscles at specific points on the body.
- **Moxibustion** – whereby indirect herbal heat is applied to specific acupuncture points.
- **Cupping** – whereby suction cups are applied to specific points on the body and on occasion are moved from point to point.
- **Electrical Stimulation** – whereby the needles are electrically stimulated at 9 volt or less to cause relaxation of the muscles and analgesia of the area of pain involved.
- **Herbal Medicine** – whereby herbs and nutritional supplements, which are from plant, animal and mineral sources are recommended.
- **Oriental Nutritional Counseling** – whereby a healthful diet is individually tailored and recommended.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Burns on the skin are a potential risk of indirect moxibustion. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. There have been extremely rare instances of spontaneous miscarriage and pneumothorax – collapsed lung.

_____ Initials

INFORMED CONSENT Cont.

ILEANA TECCHIO N.D., L.Ac., Dipl.Ac., M.S.O.M.

I understand that while this document describes the major risks of treatment, other side effects may occur. I do not expect Ileana Tecchio N.D., L.Ac. to be able to anticipate all risks and complications. I wish to rely on Ileana Tecchio N.D., L.Ac. to exercise judgment during the course of the procedure which Ileana Tecchio N.D., L.Ac. feels at the time, based on the facts then known, and is in my best interests.

_____ Initials

Herbal and nutritional supplements are traditionally considered safe in the practice of Oriental Medicine. I understand the same herbs and nutritional supplements may be inappropriate during pregnancy and **will inform Ileana Tecchio N.D., L.Ac. immediately of pregnancy status**. If I experience any gastro-intestinal reactions or any adverse effects, I will inform Ileana Tecchio N.D., L.Ac. immediately.

_____ Initials

I state that in addition to not being pregnant; I do not have the following conditions: bleeding disorders, pacemaker, local infections, diabetes, cancer, and I am not taking anti-coagulant drugs.

_____ Initials

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment. To comply with Article 160, Section 8211.1 (b) of NYS Education Law, Ileana Tecchio N.D., L.Ac. requests that you read and sign the following statement.

I/We, the undersigned, do affirm that _____ (patient) has been advised by Ileana Tecchio, N.D., L.Ac., to consult a physician regarding the condition(s) for which such patient seeks acupuncture and/or herbal medicine treatment(s).

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 Ileana Tecchio N.D., L.Ac. to contact another one of my health care providers in order to discuss any emergency situation. My signature gives Ileana Tecchio N.D., L.Ac. permission to release my medical records for the reason listed above.

I have been informed that I have the right to refuse any form of treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures.

Ileana Tecchio N.D., L.Ac., M.S.O.M., Dipl.Ac.

Patient Name _____

Patient Signature _____

Legal Guardian _____

Today's Date _____