Name:_____ DOB:_____ Date:_____

Pediatric Intake Form (*Newborn - 12 years*)

Welcome! It is my goal to provide your child with the best possible health care. In order to serve you optimally, please answer the following questions about *your child's health history* and *lifestyle. Thanks!*

NAME:_____

DOB:_____ ☐F ☐M

SS#_____ (for lab & insurance use)

ADDRESS:_____

CITY,ST,ZIP:_____

PHONE:_____

INSURANCE:_____

ID#_____

GROUP#_____

PLAN NAME_____

INSURED/SUBSCRIBER_____

INSURED/SUBSCRIBER DOB_____

INSURED/SUBSCRIBER EMPLOYER _____

_____

INSURANCE CO-PAY_____

Parent Information:

Parents: ☐ Married ☐Separated ☐Divorced

Parent's Name:_____Phone:_____

Parent's Occupation:_____Full or Part Time

Other Parent's Name:_____Phone:_____

Other parent's Occupation:_____Full or Part Time

Other Guardian: _____Relationship to child:_____

Emergency Contact : _____Relationship to child:_____

Address: _____ Phone_____

Pediatrician:_____ Phone_____

Siblings: *Name* *Age* *Health Problems*

1) _____

2) _____

3) _____

4) _____

Others Residing In Home _____ Relationship_____

Daycare/Preschool/ School _____

How Many Hours Each Day? _____ Days Of The Week?_____

Interaction with relatives: Who _____How Often?_____

Name:_____ DOB:_____ Date:_____

Present Health Concerns	Date of Onset	Current Treatment

Serious Injury or Illness (year and cause) _____

_____

Hospitalizations/Surgeries (year and reason):_____

_____

Allergies and Sensitivities (Drugs, Foods, Environmental,Chemicals, Etc)	Symptoms during an allergy attack?

Childhood illnesses
- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ Ear Infections
- ☐ German Measles
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pertussis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Tonsillitis
- ☐ Scarlet Fever
- ☐ Strep Throat
- ☐ Mononucleosis

Immunizations	Date	Adverse Reactions
☐ DTP or ☐ DTaP		
☐ MMR		
☐ Polio (☐ IPV/ ☐ OPV)		
☐ Hib		
☐ Pneumococcus (PCV)		
☐ Hep B		
☐ Varicella		
☐ TB test (pos. or neg?)		
☐ HPV		
☐		
☐		
☐		

Other Illnesses/ Trauma/Hospitalization/Surgery:

_____

_____

Name:_____ DOB:_____ Date:_____

_____

_____

Current Medications (prescription, non-prescription, vitamins, herbs, etc. Include pills, tablets, liquids, ointments, suppositories, etc. **Indicate dosage**)

Medications	*Current*	*Past*	*Frequency*	Supplements	*Current*	*Past*	*Dose*
Aspirin				Vitamins			
Tylenol				Minerals			
Antibiotics				Herbs			
Decongestants				Fluoride			

Other _____

_____

Mother's health during pregnancy and lactation: *(check; then describe below)* Age at pregnancy_____

- ☐ Alcohol Consumption
- ☐ Bleeding
- ☐ High Blood Pressure
- ☐ Medications
- ☐ Nausea
- ☐ Recreational Drugs
- ☐ Smoking
- ☐ Stress
- ☐ Toxemia
- ☐ Trauma/Injury
- ☐ X-Ray
- ☐ Other illness

Was pregnancy ☐ Easy ☐ Difficult Term: ☐ Full ☐ Premature ☐ Late Birth Weight_____

Explain: _____

_____

_____

Place of birth: ☐ Hospital ☐Home ☐ Birth Center ☐ Other:_____

Feeding: ☐ Breast milk ☐ Formula How long:_____ Type of formula_____

Age Solid Foods Begun_____ First Foods _____

Age of Introduction for : milk_____ wheat _____Favorite Foods_____

Any restrictions _____

Sample Daily Diet: *(choose a typical day, include food, liquids and amounts)*

_____

_____

_____

A Natural Path...toward health

1037 Western Ave, Brattleboro VT 802-275-5223 & 376 Pleasant Street Northampton MA 413-587-0122

Name:_____ DOB:_____ Date:_____

A Natural Path

1037 Western Ave
Brattleboro, VT05301
802-275-5223

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that A Natural Path has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. **I understand that if I have questions or complaints I may contact the office at 802-275-5223.**

I also understand I am entitled to receive updates upon request if A Natural Path changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient.

Date:_____

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF ANNA ABELE, ND IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

Name:_____ DOB:_____ Date:_____
[ ] Other (specify):

Name and title of employee_____ Date_____

Mandatory Disclosure of Information and Informed Consent for Treatment by Anna Abele, ND

** You are the most important person on your health care team. You are entitled to receive clear and understandable information about the methods of therapy, techniques used, and the duration of therapy. If you have any questions about your treatment, please feel free to contact Dr. Abele. You have the right to refuse any treatment offered. You may seek a second opinion from another health care professional, or terminate therapy at any time.*

I understand that methods of treatment may include, but are not limited to: diet and lifestyle therapies, nutritional counseling, therapeutic use of nutrients, herbal medicine, soft tissue manipulation and/or joint manipulation. I further understand that Naturopaths are not licensed in the state of Massachusetts and it is recommended that I have a primary care physician who can provide the kinds of treatment that Dr. Abele is unable to provide in this state.

Naturopathic Pharmacy:

- I understand that pharmacy items need to be prepared and consumed according to the instructions provided orally and in writing.
- Herbal Medicine: I understand that some herbs may need to be prepared. I understand that herbal tinctures are usually prepared with alcohol and will inform the physician if I cannot use them.
- I understand that some pharmacy items may have an unpleasant smell, taste or texture, which is not a reason for returning an item. However, I will immediately notify Dr. Abele of any unanticipated or unpleasant effects associated with a pharmacy item.

Manual Therapy: I understand and am informed that, as in the practice of medicine, in the practice of manual therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, strains and sprains. I understand that a minority of patients may notice stiffness or soreness after the first few days of treatment. I understand that the risk of more severe complications due to joint manipulation have been described as "rare", having been estimated at one in one million to one in twenty million, and is even further reduced by the use of screening procedures as used by Dr. Abele.

Photography: either conventional or digital may be utilized to record my condition. Photography of my condition may also be used to illustrate a patient's condition or an aspect of treatment for educational purposes. I understand that photographs form a part of my medical records and are protected in the same way as any other medical record and if used for medical illustration my privacy will be protected.
I do not expect Dr. Abele to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment, which the she thinks at the time is in my best interest based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and to discuss with Dr. Abele the nature, purpose, risks and benefits of treatments provided. I understand that not all of the above-named procedures may be utilized for my 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 understand that results are not guaranteed. I hereby request and consent to the treatment and use of the procedures listed above on me (or on the patient named below, for whom I am legally responsible).

_____

Patient signature (or gurardian) date

Name:_____ DOB:_____ Date:_____

_____
Printed name (guardian and patient if applicable)

AUTHORIZATION TO RELEASE INFORMATION REGARDING MY CARE

Please initial or sign where indicated

_____ I authorize the release of information regarding my care to the following Physicians:
Initials

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

Doctors Name: _____

Address:_____

Phone:_____

Fax:_____

Email:_____

_____ I authorize the release of information regarding my care on the voicemail or answering In
Initials machine attached to any number provided by me to ***A Natural Path LLC.***

_____ I authorize the release of information regarding my care to me by any email address
Initials provided by me to ***A Natural Path LLC.***

_____ I authorize the release of information regarding my care to the following people via any
Initials of the means provided by me to ***A Natural Path LLC.*** (___email, ___ mail, ___telephone, ___ answering machine) *please initial*

Name: _____

Name: _____

Name:_____ DOB:_____ Date:_____

Name: _____

_____ Date_____

Signature of Patient (or his/her authorized representative, or parent or guardian)

Please specify relationship to patient/client if a minor: _____

This Authorization may be revoked in whole or part at anytime by writing to A Natural Path LLC.