flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

PEDIATRIC INTAKE FORM (6-12 YEARS)

Name: _____ Date: _____

Age: _____ Date of birth: _____ Gender: Female / Male

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Parent's email address: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are? _____

_____

Reason for referral or presenting problems: _____

_____

Insurance? Yes / No Insurance Name: _____
Phone #_____
Policy/ID Number: _____
Group Number: _____
Secondary Insurance Yes / No Insurance Name:

HEALTH HISTORY QUESTIONNAIRE

Child's birth weight: _____

What are your child's most important health problems? List in order of importance:

1. _____
2. _____
3. _____
4. _____

Does your child have a contagious disease at this time? Y / N

If yes, what? _____

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

PREVIOUS ILLNESSES

Rheumatic Fever	Y N	German measles	Y N
Chicken Pox	Y N	Measles	Y N
Tonsillitis	Y N	Approx. number _____	
Ear infections	Y N	Approx. number _____	
Other	Y N	List _____	

Has your child had any of the following tests? Indicate **when** and **where** and **results**.

Electroencephalogram (EEG) _____

Psychological evaluation _____

Hearing tests _____

Speech/language tests _____

Injuries/surgeries/hospitalizations (please list): _____

_____

IMMUNIZATIONS

Polio	Y N		
Pertussis	Y N	DPT	Y N
Tetanus Shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
MMR	Y N	Hib	Y N
Chicken pox	Y N	Hep B	Y N
Adverse reactions?	Y N	If yes, what? _____	

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? _____

And foods? _____

Any environmentals? _____

Breast-fed? ___ How long? _____ Formula? _____ Milk/soy _____

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

FOR THE FOLLOWING, PLEASE CIRCLE:

Y = condition you have now **N** = never had **P** = significant problem in the past **S** = sometimes a problem

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N
Irritability	Y	P	N
Hyperactivity	Y	P	N
Introvert/extrovert	Y	P	N
Motion/car sickness	Y	P	N
Anxiety/nervousness	Y	P	N
Cries easily	Y	P	N
Unusual fears	Y	P	N
Sleep problems	Y	P	N
Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N
Fatigue	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Low blood sugar	Y	P	N
High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N
Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N
Itching	Y	P	N

HEAD

Headaches	Y	P	N
Head Injury	Y	P	N
Dizzy spells	Y	P	N
High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N
Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N

EARS

Earaches	Y	P	N
Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N
Nose Bleeds	Y	P	N
Stuffiness	Y	P	N
Hayfever	Y	P	N
Sinus problems	Y	P	N
Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N
Canker sores	Y	P	N
Breath odor	Y	P	N

RESPIRATORY

Cough	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N
Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N
Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N
Stomach aches	Y	P	N
Constipation	Y	P	N
Diarrhea	Y	P	N
Bowel Movements	How often ___		

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N
Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins or supplements your child is taking:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Is there any information about the health of your child that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! I am honored to be of service for you and your child.

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

INFORMED CONSENT & REQUEST FOR NATUROPATHIC MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Hamilton and/or Dr. Lok, having had the opportunity to discus the potential benefits, risks and hazards involved.

I, _____ , hereby request and consent to examination and treatment with naturopathic medicine by Drs. Hamilton and/or Lok, and/or other licensed doctors of naturopathic medicine who may serve as substitutes in their absence, hereafter called allied health care provider.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Hamilton and/or Dr. Lok, and/or with the allied health care provider who acts as a substitute in their absence:

1. My suspected diagnosis(es) or condition(s).
2. The nature, purpose, goals and potential benefits of the proposed care.
3. The inherent risks, complication, potential hazards or side effects of treatment(s) or procedure(s).
4. Reasonable available alternatives to the proposed treatment procedure.
5. Potential consequences if treatment or advice is not followed and/or nothing is done.

I understand that as part of the practice of naturopathic medicine, evaluations and treatment may include, but are not limited to:

- Physical exams (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments).
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular injections).
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Hydrotherapy (use of hot and cold water).
- Counseling for improved lifestyle strategies.
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians).

Potential benefits: Restoration and improvement of the body's functioning and healing capacity, relief of pain and other disease symptoms, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, aggravations of pre-existing symptoms.

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

Notice to all pregnant women: All female patients must alert the provider if they have a confirmed or suspected pregnancy as some of the therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace maker and /or cancer, for your safety it is vital to alert your provider of these conditions.

Please read and INITIAL the following:

_____ I understand that Drs. Hamilton & Lok are not licensed to prescribe any controlled substances.

_____ I understand that Drs. Hamilton and/or Lok will only prescribe medications if they believe that they are in the best interest of myself, the patient.

_____ I understand the US Food and Drug Administration has not approved all nutritional, herbal and homeopathic substances that may be prescribed.

_____ I understand that Drs. Hamilton & Lok are not psychologists or psychiatrists. Counseling services are provided for improved lifestyle strategies. I do not expect Drs. Hamilton and/or Lok, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on known facts.

_____ I understand that it is my responsibility to request that Drs. Hamilton and/or Lok explain therapies and procedures to *my* satisfaction.

_____ I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment by Drs. Hamilton and/or Lok. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____
Patient printed name

_____
Parent/guardian printed name (if patient is a minor)

_____
Patient Signature (or parent or guardian of patient is a minor)

_____
Date

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how to best contact you when needed. If you have no specific requests we will use your information provided on the intake form. Please check <u>all</u> that apply:

☐ Please do not phone me at home. Use this alternate phone number: _____

☐ Please do not phone me at work. Use this alternate phone number: _____

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address: _____

_____

☐ Other request (please describe): _____

_____

Patient name (Please print. Include parent/guardian name is patient is a minor).

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if a minor) Date

flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

OFFICE POLICIES & FINANCIAL AGREEMENT

Dear New Patient,

Welcome to Flow Natural Health Care LLC. I look forward to providing you with your health care needs. I encourage your questions and participation in all aspects of your care. Please read and **initial** the following statements:

____ Payment for all services and medicinary items is due at the time of the your visit. We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

____ I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due.

____ As your health care provider I may prescribe medication, which may be purchased at Flow Natural Health Care LLC or elsewhere. Most insurance companies do not cover pharmacy items that I prescribe and dispense.

____ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

I have read and understand the above stated policies of Flow Natural Health Care LLC and will comply with them in all respects.

_____

Patient Name (Please print. Parent or guardian if patient is a minor).

_____ _____

Patient signature (Parent or guardian if patient is a minor) Date