

Naturopathic Health Center of San Diego

11939 Rancho Bernardo Rd., Suite 120 • San Diego, CA 92128 • (858) 618-5449

Confidential Patient Information

Pediatric Intake form to be filled out by parent or legal guardian Date: _____

Child's full name _____ **Prefers to be called** _____

Sex: Male Female (circle one) Date of birth: _____ Age _____

Street Address : _____

City: _____ State: _____ Zip: _____

Insurance Provider: _____ HMO PPO Other _____

Parents/Guardians (address and phone number if different from above). Please indicate with a check mark which phone numbers we can leave a message for you, identifying ourselves by the clinic name or doctor's name:

Name _____ Name _____

Address _____ Address _____

E-Mail address: _____

Home Phone (____) _____ Home Phone (____) _____

Work (____) _____ Work (____) _____

Other (____) _____ Other (____) _____

In case of emergency, and neither parent can be reached, contact:

Name _____ Relationship: _____

Contact Numbers: _____

Pediatrician Name: _____ Office Number: (____) _____

Can we contact if we need to? Yes No

Are there any other health care providers your child sees? _____

How did you learn about our clinic? _____

Major Complaint

What brings you in for this initial visit? If a diagnosis was made, please indicate date of diagnosis and who or where it was diagnosed.

Date of last complete check up: _____

Are there any other areas you would like to work on?

How would you rate the General Health of your child: (1 being poor, 10 being excellent)

Poor 1 2 3 4 5 6 7 8 9 10 **Excellent**

Is your child on any Medications, Homeopathics or Supplements (including vitamins and herbs).
Please list dosages

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any Allergies to medications? _____

Allergies to other substances (foods/inhalants)? _____

How was the pregnancy and childbirth for birth mom? _____

Any difficulties for child following birth? _____

Has your child experienced any major childhood illnesses, accidents, hospitalizations or surgeries?
(Please include dates and child's age at the time)

Immunizations and dates if known

DTP _____ Hepatitis B _____

Polio _____ MMR _____

HbCV _____ Chickenpox (Varicella) _____

Other _____

Siblings

Name _____ Age _____ General health: Poor Fair Good

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What are some of your child's favorite activities/ hobbies:

Does your child have any fears? _____

What are your child's favorite foods and how often are they eaten?

What type of pets do you have? _____

Does anyone in the house smoke? Yes No

How many hours of TV/video games/computer games does your child engage in daily? _____

How would you rate your child's academic performance (if appropriate)

Poor fair good excellent

Is there anything else you feel we should know about your child? _____

Height: _____ Current weight: _____

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Family History: check all that apply, and indicate family member's relation to you (i.e. maternal aunt). If family member has passed away from any of the following, please indicate their approximate age at the time of their passing.

Diabetes _____

Heart disease _____

Stroke _____

Heart Attack _____

Thyroid disorders _____

Alzheimer's disease _____

Other neurological disease(indicate) _____

Hypertension _____

High Cholesterol _____

Osteoporosis _____

Cancer(Type) _____

Chronic Gastrointestinal Disease (i.e. Cohn's Disease, Ulcerative Colitis, Peptic Ulcers, Reflux)

*Indicate which of the above or any other _____

Asthma _____


Emphysema (or other chronic respiratory disorder) _____

Chronic Skin condition (i.e. Psoriasis, eczema, rosacea) _____

Alcoholism _____

Depression _____

Fax this and any other forms to (858)618-5954

 **Initial here** _____ indicating that you have read and agree to the terms of our first appointment information on the following page.

First appointment Information Please do not fax this page

Directions can be found at sandiegonaturalhealth.com click on the “Office Visits” tab, and then “Contact/Directions”

Our address is: 11939 Rancho Bernardo Rd., Suite 120, San Diego, CA 92128

Phone 858-618-5449

- **24 hours notice of cancellation:**

We require 24 hours notice of cancellation for all appointments and telephone consults. Cancellations made without 24 hours notice from the scheduled time of their appointment will be charged a cancellation fee. Monday appointments must be cancelled no later than Friday 5pm. New patients appointments are charged \$110 if they miss their appointment or cancel with less than 24 hours notice.

- **Please be on time for your appointment:**

If for some reason you are running late, please call us to let us know you are on your way. Those who arrive more than 10 minutes late for their appointment may have to reschedule their appointment and a missed appointment fee will be charged. The doctor has the option to see the patient should they arrive late, however this depends upon availability of the doctor's schedule. Those who arrive late whose appointments are kept may be charged according to the time the appointment was scheduled for.

- **What to Expect at Your First Visit**

Your doctor will be gathering information from you to make an appropriate treatment plan or to decide what labs to order. Based on the length of the visit or need for labs to be ordered, you may not receive any treatment plan at your first visit.

- **Copies of Medical Reports and Laboratory reports:**

We ask that you make copies of any pertinent previous lab reports before your visit and bring them with you. *Please do not fax them*

- **Supplements and Medications:**

If you would like us to review the supplements you are on please bring the supplement bottles with you to your visit and accurately write down or print out the product information. You may also do the same with your medications. Please be sure to double check that the medications listed on the intake form are accurate with the correct dosages.