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Pediatric Intake Form

Date: _____

Patient Name: _____ **DOB:** _____

SSN: _____ **Age:** _____

Street Address:_____

City: _____ **State:** _____ **Zip Code:**____ **Home Phone:** _____

Sex (m/f): _____ **Grade of School:** _____

Primary contact (Mother Father Other _____**)**

Contacts Phone Number: _____

Email address:_____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other:

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in: _____

Last time you had blood work done and with what physician:_____
_____

List All Surgeries & Hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List All medicines (from drugstore or prescription) child is on now:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List all supplements child is taking:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Any known Allergies to food, drugs, environment, animals: _____
_____
_____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly; NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently. Please circle the correct one for your child.**

Ear Infections: Y N P If has had, how many total:_____

Colds: Y N P If has had, how many total:_____

Strep Throat: Y N P If has had, how many total:_____

How many times has the child taken antibiotics: _____

What other medicines has the child taken and how often:

1) _____ 3) _____

2) _____ 4) _____

Hearing Tests Normal: Yes No Not Tested When? _____

Vision Tests Normal: Yes No Not Tested When? _____

Speech Impediments: Yes No Not Tested When? _____

Learning Impediments: Yes No Not Tested When? _____

Vaccination History

YES, has had; **NO,** has not; **SOME,** did not finish all shots:

MMR: Yes No Some	**DPT:** Yes No Some	**HepB:** Yes No Some
Hib: Yes No Some	**Chicken Pox:** Yes No Some	**Polio:** Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain:_____
_____

Family History

Allergies: Y N P	**Obesity:** Y N P	**Cancer:** Y N P
Tuberculosis: Y N P	**MentalIllness:** Y N P	**Cardiovascular Disease:** Y N P
Diabetes mellitus: Y N P		

Mother's Pregnancy

HistoryAge at conception: Did she have other children already? Yes No

Health During Pregnancy

Smoking: Y N	**Diabetes:** Y N	**Nausea/Vomiting:** Y N	**Coffee:** Y N
Preeclampsia: Y N	**Emotional Stress:** Y N	**Recreational Drugs:** Y N	**Vaginal Birth:** Y N
Traumatic Birth: Y N	**Length of Labor: ___**		

If the birth was difficult, please explain: _____
_____

Health of baby at birth: _____

Health History of Child

Child Breastfed: Y N For how long: _____ When put on Formula:_____
What formula was used: _____When was the child put on solid food: _____
When did child walk: _____ Talk: _____ Develop Teeth: _____

Jaundice as baby:	**Y N**	**Colic:**	**Y N**
Cradle Cap:	**Y N**	**Anemia:**	**Y N**
Eczema or Psoriasis:	**Y N**	**Asthma:**	**Y N**
Diarrhea:	**Y N**	**Warts:**	**Y N**
Constipation:	**Y N**	**Nightmares:**	**Y N**
Finicky Eating:	**Y N**	**Bed-wetting:**	**Y N**
Poor Teeth:	**Y N**	**Tantrums:**	**Y N**
Chronic Sniffles:	**Y N**	**Disobedient:**	**Y N**
Bad Foot Odor:	**Y N**	**Fears/Phobia:**	**Y N**
Very Sweaty Baby/Child:	**Y N**	**Diaper Rash**:	**Y N**
Hyperactivity:	**Y N**	**Early Puberty**:	**Y N**
Growing Pains:	**Y N**	**Stomach Aches**:	**Y N**

Any Particular household stressors child has witnessed or gone through:

1) _____ 3) _____

2) _____ 4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

_____

Do you spray pesticides, herbicides or other chemicals around your home? _____

_____

Typical Day's Diet

Breakfast:

Lunch:

Dinner:

Snacks:

Dear New Patient,

Welcome to our clinic! We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care. ***Please Initial each line item and Sign below.**

	Payment for all services and dispensary items is due at the time of the visit. **Please note that all sales are final, and there is no return on any items sold.**
	All Naturopathic medical services provided are **not covered** by any insurance company, or plan within the state of Colorado. Payment for the portion of your visit that is considered Naturopathic services, is due in full upon the date of service.
	Some insurance companies within Colorado offer plans that provide a **percentage discount** for Acupuncture services. Please call to verify your Insurance company's policy plan coverage. Payment outside of the insurance discount provided is due at the time of service.
	Out of courtesy for our wait list patients, please call the office to **cancel your appointment at least 24 hours in advance.** This allows us to provide care to our patients that need our services as soon as possible. If you fail to comply, you will be responsible for your office visit **payment in full.**
	Dr. Lum will offer **email correspondence** to patients. Please note that some **fees** may apply. Brief – generally less than 5 minutes: Complementary Moderate – generally 5-10 minutes: $25 fee Complex – generally 11-20 minutes: $50
	I give permission for the staff at Rivergate Natural Healthcare & Acupuncture to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.
	I have read and received a copy of Rivergate Natural Healthcare & Acupuncture's Notice of Privacy Practices (found on website or in office).

- As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, Visa, Debit Cards, checks and cash. There will be a **charge of $25.00 for every returned check(s).**
- You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at Rivergate Natural Healthcare & Acupuncture. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at Rivergate Natural Healthcare & Acupuncture.
- Your Naturopathic Doctor or Acupuncturist may prescribe natural medicine, which may be purchased at Rivergate Natural Healthcare & Acupuncture or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe or dispense.
- I have read and understand the above stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I agree to pay the copay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage. I authorize the release of any medical or other information necessary to process any claims. I authorize payment of medical benefits to Dr. Kristen Lum, ND, LAc, MSOM and/or Rivergate Natural Healthcare & Acupuncture, LLC for all services rendered

Patient's or Authorized Person's Signature:

Patient Name (please print):	Patient Signature	Date

RESPONSIBLE PARTY: fill out if you are not the patient but are responsible for the bill.			
Responsible Party		**Relationship to Patient**	

SIGNATURE_____DATED_____

Informed Consent and Request for Naturopathic Medical Care, Acupuncture & Classical Chinese Medicine Treatment

As a patient 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. Kristen Lum, ND, LAc, MSOM having had the opportunity to discuss the potential benefits, risks and hazards involved.

I hereby request and consent to examination and treatment with Naturopathic Medicine and Classical Chinese Medicine (CCM) by Dr. Kristen Lum, ND, LAc, MSOM and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter call *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatments.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Kristen Lum, ND, LAc, MSOM and/or with the *allied health care provider* providing backup:

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

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements)
- Botanical/herbal medicines (prescribing 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, topical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Exercise Therapy (including but not limited to standard physical therapy exercises, Gyrotonic exercises and stretches)

The scope of practice of acupuncture is outlined below. I understand that a Classical Chinese Medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body's surface)
- Use of electrical, mechanical and magnetic devices
- Moxibustion/Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua Sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary Advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential Risks: Pain, discomfort, blistering, minor bruising, discoloration, infection, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies. Allergic reaction to prescribed herbs, supplements, and prescription medications. Soft tissue or body injury from physical manipulations or exercises. Aggravation of pre-existing symptoms.

Potential Benefits: Restoration of the body's maximal and optimal function. Relief of pain and other symptoms associated with a condition or disease. Assistance with injury and disease recover. Prevention of disease or its progression.

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

techniques or any labor inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such a treatment.

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

Please Initial and Sign below.

	I understand that Dr. Kristen Lum, ND, LAc, MSOM is not licensed to prescribe any controlled substances in the state of Colorado.
	I understand the US Food and Drug Administration have not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
	I understand that Dr. Kristen Lum, ND, LAc, MSOM is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.
	I understand that Dr. Kristen Lum, ND, LAc, MSOM is not a licensed medical doctor in the state of Colorado. I also understand that Dr. Lum does maintain her license in Acupuncture in the state of Colorado.

I do not expect Dr. Kristen Lum, ND, LAc, MSOM 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 the known facts. I also understand that it is my responsibility to request that Dr. Kristen Lum, ND, LAc, MSOM 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. 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's or Authorized Person's Signature:

Patient Name (please print):	Patient Signature	Date
RESPONSIBLE PARTY: fill out if you are not the patient but are responsible for the bill.		

Responsible Party		**Relationship to Patient**	