Kwan Yin Healing Arts Center East
3115 NE Sandy Blvd, Suite 231, Portland, OR 97232
p: 503-701-8766 - f: 888-972-5173
ND PEDIATRIC/ ADOLESCENT INTAKE

Thank you for scheduling with us, we strive to provide the **best possible integrative care** for our clients. Here at the clinic we have a **team** of Naturopathic Doctors, Licensed Acupuncturists and Massage Therapists. During your initial evaluation your practitioner will do their best to do a thorough evaluation and
give you a **treatment plan**. You can assist us in that by making sure you have fully completed the **intake paperwork** enclosed. The advantage of the integrative office is that there are **many modalities** that can provide input should any of us find the need for assistance.

Please be aware that we ask patients to give us **48 hour notice** if they need to reschedule or cancel an appointment. Late cancellation or missed appointments incur a $45.00 fee or greater, as we are unable to reschedule the appointment with another patient without sufficient notice.

It will be a pleasure to support you on your path towards wellness!

Basic Information

Patient Name | **Date of Birth** | **Age** | **Gender**

Parent's/Guardian's Name | **Parent's/Guardian's Name**

Home Phone | Mobile Phone | Home Phone | Mobile Phone

Address | Address

City, State, ZIP | City, State, ZIP

Emergency Contact | **With whom does the child/adolescent live with?**

Home Phone | Mobile Phone | **How did you hear about our clinic?**

Medical Information

Holistic health care & *preventative medicine* are *only possible* when *the physician has complete understanding of the patient physically, mentally,* & *emotionally, Please complete this questionnaire as thoroughly as possible, You may mark anything you* don't understand *with a question mark.*

When & **where did your child last receive medical/health care?**

For what reason?

Medic al Concerns: Please list your child's most important health concerns, including what brings you in today

I. 3.

2. 4.

Medications & **Supplements:** Please check any your child has taken or is currently taking. IC= current, P = *past)*

Aspirin	DC DP	Decongestants	DC DP	Herbs	DC DP
Tylenol	DC DP	Vitamins	DC DP	Other:	DC DP
Antibiotics	DC DP	Minerals	DC DP		

Allergies/Special Health Considerations: Please list all known reactions to food, drugs, or other allergens.

I. 3,

2, 4.

Childhood Illnesses: Please check all that apply

D Chicken Pox	D Whooping Cough	o Pneumonia	D Tonsillitis
o Measles	D Scarlet Fever	D Asthma	D Croup
o Mumps	o Rheumatic Fever	o Mononucleosis	D Other:
D Rubella	D Strep Throat	o Ear Infections	

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Medical Information, continued

Family History: Please identify all family members who have or have had any of the following

M = mother, MGM = maternal grandmother, MGF = maternal grandfather
F = father, PGM = paternal grandmother, PGF = paternal grandfather; S = sibling

D Alcoholism:	D Cancer (type):	D High Blood Pressure:
D Allergies:	D Diabetes:	D Hypoglycemia:
D Anemia:	o Eczema:	D Mental Illness (type):
D Arthritis:	D Epilepsy:	D Obesity:
D Asthma:	o Heart Disease:	D Stroke:
D Birth *Defects:*	D Hearing Loss:	D Thyroid Disorder:
D Other, please describe:		

General Health History: Please check all that apply (C = current, P = past)

Acne	DCDP	Cradle Cap	DCDP	Headaches	DC DP
Allergies	DCDP	Depression	DCDP	Heart Murmur	DCDP
Anemia	DCDP	Diarrhea	DCDP	Insomnia	DCDP
Asthma	DCDP	Dizzy Spells	D CDP	Jaundice	DCDP
Bed Wetting	DCDP	Earaches	DCDP	Leaming Disorder	DCDP
Birth Defects	DCDP	Eczema	DCDP	Moodiness	DCDP
Colic	DCDP	Epilepsy/Seizure	DCDP	Stuffy Nose	DCDP
Constipation	DCDP	Fatigue	DCDP	Thrush	DCDP
Cough/Wheeze	DCDP	Frequent Infections	DCDP	Vomiting	DCDP
Other:			oCoP		

Immunizations: Please check all that apply, list dates given & any adverse reactions.

D DTaP (diphtheria, tetanus, pertussis)	D Influenza	o Pneumococcal
D Hepatitis A	D Meningococcal (MCV4)	D Polio
D Hepatitis B	D MMR (measles, mumps, rubella)	o Rotavirus
D HPV	o Pertussis	D Varicella
D Additional/Other:		

Hospitalizations/Surgeries/Accidents/Serious Injuries: Please list the date & describe each incident

Please describe your child's disposition or temperament In a few words,

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Daily Habits

What are your child's main interests & hobbies?

Does your child sleep well? o Y o N
Do they wake rested? DY o N
Average hours of sleep/night:
Do they spend time outside? o Yo N
Watch TV? o YD N
If yes, how many hours/day?
Interact well with others? DYD N
Computer/video games? DY D N
If yes, how many hours/day?

Any nightmares? DYDN
If so, please describe:

Exercise/Sports

Does your child exercise or play sports? o yo N
If yes, how often?

What type(s)?

Diet & Nutrition

Does your child eat at least three meals a day? o y o N
Does your child have any dietary restrictions? o yo N
If so, what are they?

Please describe your child's typical diet:

Breaktast:
Dinner:
Lunch:
Beverages:
Snacks:
Other:

Home Environment

Are there any pets in the home? o Y o N
If yes, what type and how many?

Do you know of any toxins or other hazards that the child is regularly exposed to?

Does the child have any known environmental or chemical sensitivities (e.g. perfumes, detergents, odors, soaps, etc.)?

How would you describe the emotional climate of the child's home?

Informed Consent and Request for Care (Naturopathic)

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. Amalia Treadwell, ND/LAc, Dr. Ashlie Hempstead ND/LAc, Dr. Clara Fashana ND/LAc, Dr. Ilana Gurevich ND/LAc, Dr. Rebecca Principe ND, Dr. Natalie Hanan ND/LAc, Dr.Kathryn Kloos ND/ LMT having had the opportunity to discuss the potential benefits, risks, and hazards involved.

I, _____, hereby request and consent to examination and treatment with the above-mentioned provider.

I understand that I have the right to ask questions and discuss my case, to my satisfaction, with the above-mentioned provider and/or with the backup allied health care provider at **Kwan Yin Healing Arts Center East**. This information may include, but is not limited to:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of the treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done
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Naturopathic Evaluation Information:

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

- Physical exam (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
- Soft tissue and osseous (bone) manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage [to relieve muscular discomfort associated with pregnancy], muscle energy technique, CranioSacral therapy, and Visceral Manipulation)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- 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, and/or 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, which may include transcutaneous electrode stimulation)
- Counseling (including, but not limited to, visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

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

Potential Risks: Pain, discomfort, blistering, minor bruising, discoloration of skin, infections, burns, or itching; Loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs or supplements; Soft tissue or bony injury from physical manipulations; Aggravation of pre-existing symptoms.

Notice to Pregnant Women: All female patients must alert the provider if they have confirmed or suspected 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. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

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

Please INITIAL the following:

____I understand that the above-mentioned provider(s) are not licensed to prescribe any controlled substances.

_____I understand that the above-mentioned provider(s) will only prescribe mediations if they believe that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescription medication needs.

_____I understand that the US Food and Drug Administration has not approved nutritional, herbal, and homeopathic substances, however, these have been used widely in Europe, China, and the USA for years.

_____I understand that the above-mentioned provider(s) is not a psychologist or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above-mentioned provider(s) 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 the above-mentioned provider(s) explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended form 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.

_____

Printed Name of Patient Signature of Patient Date

_____

Printed Name of Guardian/Guarantor Signature of Guardian/ Guarantor Date