Pediatric Intake Paperwork

True Health
NATUROPATHIC MEDICINE
Nutrition Counseling · Dispensary

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INSTRUCTIONS FOR COMPLETION: The first three pages of this document are meant to be kept for your own personal records. We ask that you read through this overview and ask any questions that you may have regarding our practice, policies, and procedures. Please complete all the included intake forms including the three-day food journal. Your intake forms MUST be completed for your appointment and either brought with you for an office visit or delivered to our office prior to a phone appointment.

Welcome to True Health! We are a naturopathic medicine clinic specializing in naturopathic functional medicine, clinical nutrition, and lifestyle management. Your questions are important to us as we want you to feel confident and comfortable as a new patient. We are happy to answer any inquiries that you may have regarding your intake paperwork or new patient experience, so please, don't hesitate to ask. This introductory packet will provide you with the necessary information you need for your first appointment, as well as clinic policies, billing information, and some background on our primary practitioner, Dr. Tricia Paulson.

Naturopathic doctors are trained to work with the healing power of nature, building health, and restoring wellness, not simply treating symptoms or disease. The emphasis is not on directly treating disease but rather to strengthen the body's vital force and stimulate true healing of the body. Symptoms are an expression that the body is experiencing some type of dysfunction from within; instead of palliating these symptoms, we look for the cause of the problem and address this dysfunction through an individualized plan.

Our clinic specializes in integrating a blend of modalities that work synergistically to improve your life and your health. As a part of your care, the following services maybe recommended: biometrics testing, laboratory testing, therapeutic lifestyle management, clinical nutrition, physical movement, nutritional supplementation, Chinese medicine, homeopathy, stress management, individualized meal planning, and health coaching.

Board-certified naturopathic doctors attend four years of post-graduate doctoral medical training at an accredited school where they are trained as primary care physicians integrating traditional healing methods with modern scientific medicine. The training involves four years of classes with two years of supervised clinical rotations applied toward becoming a primary care physician. The initial curriculum is comparable to the foundation of classes in conventional medicine covering the sciences and clinical diagnosis of illness and disease. Naturopathic students complete extensive additional training in diet and nutrient therapies, botanical medicine, osseous and soft tissue manipulation, hydrotherapy, counseling, and homeopathy. To be licensable, the naturopathic doctor must pass a set of science boards taken after the second year and a set of clinical board exams taken after the fourth year. There are over 25 states that license naturopathic doctors. Wisconsin is strongly lobbying strong for licensure.

Dr. Paulson is a graduate of the Canadian College of Naturopathic Medicine, one of two accredited naturopathic schools in Canada. She currently has a license in the province of Ontario as she awaits Wisconsin to become a licensed state.

Client's Bill of Rights in Wisconsin

The state of Wisconsin has not adopted any education and training standards for unlicensed complementary and alternative health care providers. This statement of credentials is for informational purposes only.

An unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician or any other type of health care provider, the client may seek such services at any time. A client has the right to choose freely among available practitioners and to change practitioners after service has begun, within the limits of health insurance, medical assistance or other health programs.

Every client has a right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service. All information provided during office visits, charted notes, and lab reports are confidential unless a release of records is authorized in writing by the client or otherwise provided by the law. All clients have the right to access their records. It is our policy to provide copies of all new laboratory reports to clients at the time of their follow up appointment.

POLICY STATEMENT AND GENERAL INFORMATION

Website:
Visit www.truehealthnm.com or our Facebook page for the most up-to-date clinic information. From our website, you can schedule appointments and order supplements as a registered patient. Our site is a great place to learn more about the types of services that we offer and explore our approach to variety of health concerns. Our Facebook page connects you to weekly updates and featured posts from Dr. Paulson.

Appointments:
Initial phone visits are almost always scheduled for 60-90 minutes, unless we feel that more time may be needed to provide you with the most comprehensive care. Patients are only billed for the time spent in the appointment with the doctor for their initial appointment and their on-going case management. Follow-up appointment time will vary depending on the patient's need and services rendered, with the average length of a follow-up appointment lasting between 15-30 minutes. All clients are met with on an appointment basis. We respect your time and will contact you if a situation arises that may not permit us from keeping our scheduled time. You will be contacted as soon as possible to reschedule your visit. We ask you respect our time as well with the same courtesy.

Email and Telephone Consultations vs. Appointments:
Patients are encouraged to call or email with questions regarding to their most recent treatment plan. Dr. Paulson or her assistant may be able to provide clarification on instructions or procedures previously given. If you have a new question or concern that requires you to speak with Dr. Paulson for a modification to your care plan, you will be asked to schedule a follow-up appointment. Emails that indicate a need for a follow-up may prompt a request to initiate an appointment in lieu of a written response. Any call or visit that requires new instructions, case analysis, or treatment recommendations from Dr. Paulson will be billed at the same per minute rate a phone visit. A credit card must be provided for this service.

Appointment Fee Schedule:

Naturopathic doctor appointments	$180/hr
Labs & Supplements	Priced as listed

Payment:
Payment is DUE IN FULL AT THE TIME OF THE VISIT. All phone visits must be paid by credit card immediately after the completion of the appointment. If you are requesting that we send a supplement order or laboratory test kits, payment must be made before we will ship your items. Credit card services are available for Visa, Mastercard, and Discover.

Insurance:
Most insurance companies do not cover naturopathic care. Some patients do have HSA plans that maybe used for payment. Clients may submit claims for reimbursement on their own if they so choose. We are happy to provide any supporting documents you may need to submit your claim. There is no fee for this service. There are a growing number of plan providers offering private options or Flex benefits. In most cases, patients must provide detailed letters of medical necessity with accompanying documentation and billing codes. **There is a fee for this service billed at a rate of $25/hr.** We will discuss this with you on a case-by-case basis if this service is deemed necessary.

Past-Due Accounts:
We really dislike having to penalize our patients for returned checks, but as a business, we get charged for them too. Any returned check will incur a $30 fee. ANY account with a balance that has had no payment activity for more than 90 days will be turned over to a collection agency.

Mail Order/Drop Shipment Services:
If you need supplements shipped to you that are not available through our on-line stores, we will gladly send these out to you. There is an average shipping fee of $8 per order unless your order exceeds $100, in which case, shipping is free. Our policy for mail orders or drop shipments is that they are paid in full by credit card or check prior to shipping.

Notice of Privacy Practices (HIPPA):
Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Public law 104-191, published December 28, 2000, buy the US Department of Health and Human Services, we are required to notify you of our use of your Protected Health Information (PHI). The law allows the clinic to collect and use PHI from you for the use of health care purposes only. Health care purposes only refers to normal release of the practitioner's notes and/or examination findings to insurance companies authorized to reimburse this clinic for incurred charges by the client named below or signed by their representatives as stated below. This clinic will ensure that health information is not used for non-health purposes. PHI will be disclosed only for the purpose of health care treatment, payment, and operations as allowed by HIIPA. Any non-routine disclosure of your PHI will be prohibited without signed, informed consent by yourself agreeing to such disclosures. I understand my rights under HIPPA and authorize the release of my PHI for routine health care treatment, payment and operations. I understand I have the right to inspect, get copies, and request amendments be made to my file at any time. I also have the right to request information from this clinic by alternative means. Any non-routine disclosures must be authorized by myself via a signed consent. I understand that I have the right to complain to this clinic's owner, Tricia Paulson, or to file a formal complaint to the Secretary of the Department of Health and Human Services if I feel my PHI rights have been violated. I understand that these privacy policies may change in the future.

A SEPARATE DOCUMENT ENTITLED THE "DECLARATION AND CONSENT TO TREATMENT" WILL REQUIRE THAT YOU SIGN AND DATE A FORM STATING THAT THIS DOCUMENT HAS BEEN PROVIDED FOR YOU.

True Health Naturopathic Medicine LLC
Declaration and Consent to Treatment

Name_____Date of Birth _____

Address_____

The undersigned understands that any treatment or advice provided by True Health Naturopathic Clinic is not mutually exclusive from any treatment or advice that the undersigned may now be receiving or may in the future receive from another health care provider. The undersigned is at liberty to seek or continue medical care from a medical doctor, surgeon, or any other health care provider. No person has suggested or recommended that the undersigned refrain from seeking or following the advice of another health care provider.

The undersigned also understands that the treatments and/or procedures used by True Health Naturopathic Clinic may differ from those usually offered by conventional medicine. The undersigned is aware that the practice of naturopathic medicine is not for acute emergency type care, is not an exact science, and acknowledges that no guarantees have been made as to the results of treatment.

The undersigned also understands that the treatments and/or procedures used by True Health Naturopathic Clinic are of a naturopathic/alternative practice and can be used as complementary health care along with allopathic or conventional medicine. True Health Naturopathic Clinic practitioners may suggest a referral to another practitioner if they find it appropriate, including a conventional practitioner.

I have received copies of the following documents for True Health Naturopathic Clinic; I have read and fully understand the contents of these documents.

___Clinic Introductory Letter
___Notice of Privacy Practices (HIPPA)
___Declaration and Consent to Treatment

_____ Date_____
(Client signature or guardian signature if under 18 years old)

Billing Policy
All services including labs and supplements provided must be paid for on the day of service by the payment method of your choice. If you are completing a phone visit and we are sending supplements to you, payment must be received before supplements will be mailed. Should you find that you are unable to pay in full, we will work with you to create a reasonable payment plan. In the event that the terms of the payment plan are not met, any outstanding balances may be submitted to collections after 90 days of inactivity.

____I prefer to pay by credit card
Number_____ Exp. Date_____ CV Code_____ Zip Code_____

Signature_____Date_____

___I prefer to pay for services and or supplements at the time of visit with cash/check. (Office only)

Consent for Electronic Communication

On occasion our office may need to communicate with you electronically. By utilizing our practice's electronic services, you agree that True Health Naturopathic Medicine may send to you any of the following that you identify as communication that can be sent through the internet to an email address you designate.

Consent and Acknowledgement

I, _____, agree that True Health Naturopathic Medicine may electronically communicate with me at the following email address.

Email address: _____

Patient's Name: _____ Patients Date of Birth: _____

Patient's Name: _____ Patients Date of Birth: _____

Patient's Name: _____ Patients Date of Birth: _____

Patient's Name: _____ Patients Date of Birth: _____

I acknowledge that the practice may send the following to my email. Check each that apply and then provide your initials at the end of each item selected.

- O Information about my invoice or accounts payable. _____ (initial)
- O Information about my appointments. _____ (initial)
- O Information about health concerns and recommendations for lifestyle, supplements, or any other instructions regarding my health concerns. _____ (initial)

I acknowledge each of the following four statements, which is necessary before True Health Naturopathic Medicine can send communications electronically. _____ (initial)

- O Electronic communications sent to your personal email from True Health are not encrypted.
- O I am responsible for providing True Health with any updates to my email address.
- O I am able to receive information electronically and store it securely away from any public computer.
- O I can withdraw my consent to electronic communications by calling (715) 483-1315.

Print Name: _____ Signature: _____ Date: _____

Relationship to patient (if patient is a minor or is unable to sign): _____

For office use only

We attempted to obtain written acknowledgement and consent for electronic communication but acknowledgement could not be obtained because:

- O Individual refused to sign
- O Communication barriers prohibited obtaining the acknowledgement
- O An emergency situation prevented us from obtaining acknowledgement
- O Other : _____

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Please return your intake paperwork via email or fax at least 24-hours prior to your appointment.

admin@truehealthnm.com
Fax (715) 350-7878

Name:_____ Birthdate:_____/_____/_____ Age:_____

Address:_____ City, State:_____ Zip:_____

Preferred Phone Numbers:_____ and _____ (C, H, W)

Parent's Email:_____

Grade in School: _____How did you hear about True Health?_____

Can we thank your referrer? ☐Y ☐N Emergency Contact: (Name/Phone):_____

Medical Doctor:_____ Date of last physical:_____

Other Healthcare Providers (Name/Type):_____

HEALTH INFORMATION

What is your main health concern?_____

Please list any other concerns (physical, emotional, or mental) in order of importance. Please indicate the date of onset, current or past treatment or care approaches and what you feel may be contributing to or causing the concern or symptom.

Concern	Onset	Treatment or Care
Contributors		

Concern	Onset	Treatment or Care
Contributors		

Concern	Onset	Treatment or Care
Contributors		

Overview

What are your treatment goals and expectations for the care of your child?

_____

_____

How would you rate your child's overall health? ☐Poor ☐Fair ☐Good ☐Excellent

Use the following scale to answer the following questions: Low 1 2 3 4 5 6 7 8 9 10 High

How committed are you in taking responsibility for following through on your child's treatment? _____

How committed are you in making dietary changes that could positively enhance your child's health? _____

How confident are you that your child's plan will be supported by the family and friends in your life?_____

Health Timeline

Please list the most serious injuries, illnesses, drug reactions, hospitalizations, or events from birth to present.

Age	**Event**

Are there any major life events (move, divorce, death, abuse, adoption) that you feel may be correlated to your child's health problems? Please indicate in the box below.

Childhood Illnesses

Please check off any illnesses with an X that your child has experienced.

	Acute Epiglottitis		Conjunctivitis (Pink Eye)		Pneumonia
	ADHD/ADD		Congenital Diseases		Recurrent Ear Infections
	Allergies to_____		Diabetes (Type I)		Rheumatic Fever
	Anemia		Frequent Colds		Rubella
	Appendicitis		Fevers		Scarlet Fever
	Asthma		Head Lice		Seizures
	Autism		Impetigo		Sinusitis
	Bronchitis		Measles		Thrush
	Cancer		Meningitis		Tonsillitis/Strep Throat
	Chicken Pox		Mononucleosis		Urinary Tract Infections
	Cold Sores		Mumps		Whooping Cough

Please add any additional notes pertaining to illness here: _____

_____

Symptoms of Illness

Please place an X in the appropriate box for any symptoms your child has experienced.

Past	Now		Past	Now		Past	Now	
		Appetite Change			Diarrhea			Indigestion
		Bad Breath			Diaper Rash/Itchy Rectum			Insomnia
		Bed Wetting			Difficulty Concentrating			Nervousness
		Burning Urination			Difficulty Sleeping			Night Sweats
		Chronic Bleeding Nose			Dizziness			Sore Throat
		Chronic Runny Nose			Easy/Chronic Bruising			Stomach Aches
		Colic/Gas/Cramping			Eczema/Hives			Temper Tantrums
		Constipation			Fatigue			Urinary Frequency
		Cough			Hair Loss			Visual Disturbances
		Cradle Cap			Headaches			Vomiting
		Cries Easily			Hearing Loss			Wheezing

Medications & Supplements

Medication	Dose & x/day	Duration	Medication	Dose & x/day	Duration

Please list any over-the-counter medications that your child currently takes or has taken in the past. These would include pain relievers, laxatives, topical steroids, proton-pump-inhibitors (Prilosec), etc. Please indicate frequency and duration of use.

Supplements	Dose & x/day	Duration	Supplements	Dose & x/day	Duration

Allergies: Please list any known allergies that your child has (medication, supplement, food, environmental, animal, other) and the type of reaction that they experience (anaphylactic, sensitivity, etc.).

Allergen	Reaction

Environmental Exposure: Please recall any toxic or environmental exposures your child may have had. – chemicals, solvents, pesticides, dental fillings, power lines, molds, cigarette smoke, surgical implants, etc. **Also, if your child has frequent contact with animals, please list what kind and how often.**

Child's Immunization History

Please place an "X" in front of any immunizations that your child has received.

	DPT		Tetanus & Booster		Hep. B
	Small Pox		Varicella		MMR
	HIB		Hep. A		Polio

Has your child received the flu vaccination? _____

Are there any additional vaccinations that your child has received? _____

_____

Pregnancy & Birth

Please indicate the quality of the indicated health factors with an X

Parental Health/Well-Being	Excellent	Good	Fair	Poor	Unknown
Health of mother at time of conception					
Health of father at time of conception					
Health of mother during pregnancy					
Emotional state of mother during pregnancy					
Mother's diet during pregnancy					

Please indicate if the birth mother experienced any of the following during pregnancy:

- ☐ Hypertension
- ☐ Bleeding
- ☐ Trauma
- ☐ Gestational diabetes
- ☐ Excessive vomiting/nausea
- ☐ Maternal rubella
- ☐ Pre-eclampsia
- ☐ Anemia
- ☐ Maternal toxoplasmosis
- ☐ Eclampsia
- ☐ Placenta previa
- ☐ Cold/Flu
- ☐ Other—please indicate

Substances used during pregnancy by the birth mother:

- ☐ Tobacco
- ☐ Alcohol
- ☐ Caffeine
- ☐ Recreational drugs
- ☐ Prescription medications
- ☐ Herbal preparations
- ☐ Over the counter drugs
- ☐ Other_____

Length of pregnancy:_____weeks **Interventions during the pregnancy:** ☐ Ultrasound ☐ Amniocentesis

Labor & Delivery

Type of labor: ☐ Spontaneous ☐ Induced Other_____

Type of delivery: ☐ Vaginal ☐ C-Section Other_____

Location of birth: ☐ Hospital ☐ Home Other_____

Interventions during the delivery: ☐ Epidural ☐ Forceps ☐ Suction Other_____

Complications with the delivery: ☐ Difficult ☐ Long ☐ Breech ☐ Shoulder Dystocia

Birth weight:_____lbs **Length:**_____in. **Interventions administered after birth:** ☐ Vitamin K ☐ Eye drops

Complications After Delivery

- ☐ Jaundice
- ☐ Respiratory distress
- ☐ Hip displacement
- ☐ Rash
- ☐ Birth-defects
- ☐ Scoliosis
- ☐ Colic
- ☐ Bleeding
- ☐ Injuries during birth
- ☐ Seizures
- ☐ Fever
- ☐ Infections
- ☐ Swallowed/aspirated on meconium
- ☐ Other—please indicate

Feeding & Food Introduction

Breast fed: ☐ Yes ☐ No If yes, how long? _____ **Bottle fed:** ☐ Yes ☐ No If yes, how long? _____

Please indicate what type of formula was used (dairy-based, soy, other) and if it was combined with breast milk. Please share any other details pertaining to early nutrition such as any reactions to either the formula or breast milk (colic, gas, constipation, rashes, etc.).

When were solid foods first introduced? _____ Please provide the order of first food introductions and indicate if they were fresh or preserved (jarred baby food). Please share any details related to reactions to the foods that were introduced (colic, gas, constipation, rashes, etc.).

Developmental Milestones

At what age did your child: crawl _____ walk _____talk _____toilet train _____

Current Lifestyle Patterns

Is your child currently in school, daycare, at home? _____

How would you describe your child's behavior? Indicate if there are times of day or situations in which it varies. Note differences between home/school/daycare, etc.

Does your child watch TV?	☐ Yes	☐ No	How often?	
Does your child play video games?	☐ Yes	☐ No	How often?	
Does your child play on the internet?	☐ Yes	☐ No	How often?	
Does your child have family time?	☐ Yes	☐ No	How often?	
Does your child get exercise?	☐ Yes	☐ No	How often?	
What does your child like to do for exercise?				
What are your child's hobbies/interests?				

Please write a short description of your child as they are currently. Include insights and reflections on their personalities and traits.

Is there anything that you feel that is important that has not been covered?

Energy & Sleep

Rate your child's energy between 1 (low) and 10 (high) _____

What time of the day is your child's energy the highest? _____ the lowest?_____

What time does your child wake up? _____ What time do they go to bed? _____ Hour of sleep _____

Does your child nap? If yes, when and how long?_____

What position does your child sleep in?_____

☐ Difficulty falling asleep	☐ Does not sleep through the night	☐ Talks in sleep
☐ Nightmares	☐ Sleeps with a night light	☐ Sleep walks
☐ Night terrors	☐ Wakes unrefreshed	☐ Bed-wetting

Food Journal & Inquiry: So much of our health is influenced by the foods that we eat on a regular basis. For each of the meal times listed below, please provide several examples of the types of food that your child eats on a regular basis. Please be a bit specific with your examples such as, "Cheerios cereal (about 2 cups) with a whole banana and skim milk," versus, "Cereal and milk."

Breakfast	
Lunch	
Dinner	
Healthy Snacks	
"Unhealthy" Snacks	
Beverages	

Please provide any additional insights that you have around food for your child. Do you notice any patterns to what or when they eat? Do they gravitate towards certain foods? Is there anything they eat that changes behavior? Are there any foods that seem to cause digestive upset? Do they have any food cravings?

Bowel Habits: Please describe current bowel habits regarding frequency of stool per day/week along with remarks on consistency/form. _____

Family Health History

Please indicate any familial history of the listed conditions by placing an X in the appropriate boxes.
Key: M=mother, F=father, S=sibling, A/U=aunt or uncle, GP=grandparent

Condition	M	F	S	A/U	GP	Condition	M	F	S	A/U	GP
Alcoholism						Heart disease					
Allergies						Kidney disease					
Alzheimer's disease						Liver disease					
Arthritis						Depression					
Asthma						Osteoporosis					
Autoimmune disease (specify)						Parkinson's disease					
Cancer (specify)						Seizure/Epilepsy					
Crohn's or Colitis						Stroke or Aneurysm					
Drug addiction						Thyroid condition					
Diabetes						Tuberculosis					
Eczema						Other:					

Please specify autoimmune disease or cancer type from above:_____

Female Reproductive Health History (If menstruating)

Age of first period_____ Date of last period_____ Length of flow (days)_____

Length of complete cycle (days)_____ Color of blood: ☐bright ☐light ☐dark Do you use tampons? ☐Yes ☐No

With your period, do you experience...

A heavy flow? ☐Yes ☐No

Clotting? ☐Yes ☐No

A light flow? ☐Yes ☐No

Low back pain? ☐Yes ☐No

Menstrual cramps? ☐Yes ☐No

Before your period, do you experience...

PMS? ☐Yes ☐No

Mood swings? ☐Yes ☐No

Headaches? ☐Yes ☐No

Breast tenderness? ☐Yes ☐No

Water retention/bloating? ☐Yes ☐No

Please add any additional information that you feel is relevant to today's visit.