Dr. Paloma Defuentes
Naturopathic Physician
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MT Naturopathic Clinic
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Bozeman, MT 59715

Pediatric Patient Intake Form Age 0-5

By completing this profile of your child's health history, I can offer your child more complete naturopathic care.

Please complete this confidential intake form. Completed by____

Relationship to patient____

Parent'sName(s)____

Email address ____

Patient's Name ____________________________________ Age _________ Birth Date___________________

Address ___________________________ City _______________________ State _________ Zip _______________

Social Security # _______________________ Home Phone _________________ Work Phone __________________

Sibling(s) gender(s) and ages:____

How did you hear about us? ____

Where, when, from whom, and for what reason did your child last receive any health care? ___________________

____

____

Please list, in order of importance, your health concerns and/or goals for your child.

1. ____

2. ____

3. ____

Has your child received any vaccinations? Y N

If yes, which ones, including dates:

____

____

____

Any problems with vaccinations? Y N Please explain:

____

____

Family Health History: Y=Yes N=No D=Caused Death (age of death) P=In the past
Please indicate if a family member has had any of the following. If yes, specify who.

Anemia	Y	N	D	P	______________________
Arthritis	Y	N	D	P	______________________
Asthma / Hay fever	Y	N	D	P	______________________
Cancer (type?)	Y	N	D	P	______________________
Cystic Fibrosis	Y	N	D	P	______________________
Diabetes	Y	N	D	P	______________________
Eating Disorder	Y	N	D	P	______________________
Epilepsy	Y	N	D	P	______________________
Fibromyalgia	Y	N	D	P	______________________
Glaucoma	Y	N	D	P	______________________
Heart Disease (incl heart attacks)	Y	N	D	P	______________________
Hypertension (high blood pressure)	Y	N	D	P	______________________
Kidney Disease	Y	N	D	P	______________________
Lung Disease	Y	N	D	P	______________________
Mental Illness	Y	N	D	P	______________________
Obesity	Y	N	D	P	______________________
Stroke	Y	N	D	P	______________________
Substance Abuse (drugs, alcohol)	Y	N	D	P	______________________
Venereal Disease	Y	N	D	P	______________________

Blood Type (please circle) **A** **B** **AB** **0**

Illnesses Please circle if your child has had any of the following:

Scarlet fever Measles Diphtheria Rubella (German measles) Chicken pox

Rheumatic fever Mumps Others ____

Date of last Tetanus shot ________________________

Allergies:

Drugs? ____

Foods? ____

Environmental? ____

Hospitalizations? Please list when and why.

Illnesses: ____

Surgeries: ____

Other: ____

Medications: Please indicate if your child has used any of the following.

Antibiotics Y N P How often? _____________________________________ Laxatives Y N

Cortisone Y N P Crème Y N P Tablets Y N P

Others ____

Hospitalizations Y N

If yes, please list:

____

Current prescription medications:

____

____

Current over-the-counter medications:

____

____

Current vitamin/herbal supplements:

____

____

Pregnancy, Labor & Delivery: Home hospital birth?

Any problems? Y N

If Yes, please explain:

____

Alcohol or drug use during pregnancy? Y N
If Yes, please explain:

____

Gestational Diabetes? Y N
If Yes, please explain:

____

Breastfeeding? Y N If yes, Duration: ____________________ Age of weaning ____________________

Formula Feeding Y N

If Yes: Cow's milk Soy Other: ______________ Duration & Age of weaning ________________________

Health Conditions Y = Yes N = No P = A condition your child has had in the past

Skin

Acne	Y	N	P	Boils	Y	N	P
Color Changes	Y	N	P	Eczema	Y	N	P
Hives	Y	N	P	Itching	Y	N	P
Lumps	Y	N	P	Moles	Y	N	P
Rashes	Y	N	P	Psoriasis	Y	N	P

Head

Injuries	Y	N	P	Headaches	Y	N	P
Forceps delivery	Y	N	P	Fontanelle issues	Y	N	P

Eyes

Lazy eye	Y	N	P	Injuries	Y	N	P
Glasses/Contacts	Y	N	P	Infections	Y	N	P

Ears

Infections	Y	N	P	Discharge	Y	N	P
Injuries	Y	N	P	Hearing issues	Y	N	P

Nose and Sinuses

Discharge	Y	N	P	Frequent colds	Y	N	P
Stuffiness	Y	N	P	Bleeding	Y	N	P

Teeth, Neck and Throat

Speech problems	Y	N	P	Swollen glands	Y	N	P
Neck injuries	Y	N	P	Swallowing issues	Y	N	P
Dental cavities	Y	N	P	Sore throat	Y	N	P

Teething:

1st Tooth________months Problems?____

Molars__________months Problems?____

Baby tooth loss Y N If Y: ____

Respiratory

Asthma	Y	N	P	Bronchitis	Y	N	P
Coughs	Y	N	P	Pneumonia	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P
Spitting up blood	Y	N	P	with exertion	Y	N	P
Difficult/Painful breathing	Y	N	P	while lying down	Y	N	P
2nd Hand Smoke Exposure	Y	N	P				

Cardiovascular

Murmurs	Y	N	P	Congenital issues	Y	N	P

Gastrointestinal

Blood in stool	Y	N	P	Belching/Passing gas	Y	N	P
Change in thirst	Y	N	P	Change in appetite	Y	N	P
Heartburn	Y	N	P	Vomiting	Y	N	P
Hemorrhoids	Y	N	P	Jaundice/Yellow skin	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hernia	Y	N	P	Constipation	Y	N	P
Diarrhea	Y	N	P	Abdominal pain	Y	N	P

Bowel movements: How often? ___________x/day Is this a change? Y N

Consistency & Color ___________________ Foul odor? Y N

Undigested food in stool (pieces of vegetables/grains) Y N

Urinary

Diapers/day ___________ Age of Toilet Training__________

Frequent infections	Y	N	P	Discharge	Y	N	P
Pain with urination	Y	N	P	Increased frequency	Y	N	P
Bedwetting	Y	N	P				

Females

Inguinal hernia	Y	N	P	Vaginal discharge	Y	N	P

Males

Inguinal hernia	Y	N	P	Undescended testicle	Y	N	P

Musculoskeletal

Growing Pains	Y	N	P	Muscle cramps/spasms	Y	N	P
Joint pain/stiffness	Y	N	P	Broken bones	Y	N	P
Joint swelling	Y	N	P	Muscle weakness	Y	N	P

Neurological

Dizziness	Y	N	P	Numbness/tingling	Y	N	P
Fainting	Y	N	P	Seizures	Y	N	P
Paralysis	Y	N	P	Tremors	Y	N	P

Endocrine

Excessive hunger	Y	N	P	Excessive thirst	Y	N	P
Excessive fatigue	Y	N	P	Difficulty falling asleep	Y	N	P
				Difficulty staying asleep	Y	N	P

Mental & Emotional Health

Fears: Y N

If Y, explain: ____

____

Tantrums: Y N

If Y, explain____

Mood swings: Y N

If Y, explain: ____

Separation anxiety: Y N

If Y, explain: ____

Reaction to foods (food dyes, artificial sweeteners, etc.): Y N

If Y, explain: ____

Socialization, Personality, & Home life

Bed time ____________________________Consistent? ________________Hours of sleep per night ______________

Waking time in morning ____ Consistent ___________________________

Naps per day and duration _______________________________________ Frequent waking: Y N

Daycare: Y N Preschool: Y N Playgroup: Y N

Brushes teeth: Y N

Bathing routine ____

Interaction with other kids: Leader or follower?

Further explanation if any: ____

____

Siblings: Y N If Yes, Ages & gender: ____

Watches TV: Y N
If Yes, What programs? ____

____

Hours of TV per day: ___________ Supervised? Y N

Video Games? Y N Hours daily: ______________________

Do you read books together? Y N
If Yes, Hours daily: ____

Learning problems? Y N
If Yes, explain: ____

Problems with social interactions? Y N

If Yes, explain: ____

____

Diet and Nutrition

Please list foods for a typical day:

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

Food cravings: ______________________________ Food aversions: ______________________________

Beverages: ______________________________Amount per day: ______________________________

Current height: ______________ Current weight: ___________________

Thank you for taking the time to fill out this form completely. Don't worry if you were not able to answer some of the questions. During your office visit, we will discuss some of your responses in detail. Please feel free to attach any additional sheets describing your medical history or symptoms in detail.

Consent to Naturopathic Treatment Provided by Paloma Defuentes, N.D.

1. This is to acknowledge that I have been informed and understand that:

a) Any treatment or advice provided to me as a patient of Paloma Defuentes, N.D. is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
b) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.
c) I understand that Paloma Defuentes, N.D. is not preventing me from seeking or following the advice of another licensed health care provider.
d) The treatment and therapies provided to me by Paloma Defuentes, N.D. may be different from those offered by another licensed health care provider.

2. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees at the time of the visit.

3. I hereby authorize and consent to treatment.

4. I understand that what we talk about will remain confidential with the exception of a case where I feel you or someone else will get hurt. This includes such things as: suicide, homicide, and reportable crimes such as physical or sexual abuse. If you have questions, please ask me.

5. I understand that the information I provide will be handled in accordance with patient confidentiality and HIPPA laws.

6. I understand that this office uses an outside billing agency for billing.

7. Authorization/Assignment: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be paid to Montana Naturopathic Clinic and I'm fully financially responsible for non-covered services. I understand and agree to pay any collection fees, interest, court fees, and attorney fees if my account is placed in collections or court for non-payment.

8. Please refer to the HIPPA policy on my website under the "Clinic Forms" tab.

9. I have read and agree to all terms and policies.

____ Date: _____________________
Patient Guardian Signature