

Pediatric Intake Packet (6 to 12 years)

Welcome to Vital Source Medicine, PLLC. In order to provide your child with the best possible care, we ask you to complete this form in its entirety. Thank you!

Patient Information

Name: _____ Date: _____

Parent's names: _____

Address: _____ City, State, Zip: _____

Telephone: (home): _____ (Parent's work): _____ (cell): _____

Preferred number for messages and appointment reminders? _____

Can Vital Source Natural Medicine identify themselves when leaving a message? _____

Is it okay to leave a message with detailed information? _____

Parent's e-mail: _____

Age: _____ Date of Birth: _____ Gender: F M Ethnic heritage: _____

How did you hear about this clinic? _____

May we thank them for the referral? yes ____ no ____

Do you have a primary care pediatrician? Y / N

Name: _____

Other healthcare providers your child see on a regular basis: _____

Reason for today's visit or chief complaint: _____

Health History

What are your child's **most important health concerns**?

1) _____

2) _____

3) _____

Does your child have any known contagious diseases at this time? Y / N

If yes, what? _____

Was your child breastfed? Y / N For how long? _____

Has your child been exposed to second hand smoke? Y / N For how long? _____

Previous Illnesses

Rheumatic fever	Y N	Mumps	Y N
Chicken Pox	Y N	Measles	Y N
Scarlet fever	Y N	Rubella	Y N
Frequent colds	Y N	Pneumonia	Y N
Ear infections	Y N	Approx. no. of times:	_____
Strep throat	Y N	Approx. no. of times:	_____
Tonsillitis	Y N	Approx. no. of times:	_____
Antibiotics	Y N	Approx. no. of times:	_____
Other: _____			

Past Medical History: Hospitalizations, Surgeries, Major Events

What hospitalizations, surgeries, and other major past medical history has your child had?

_____ year: _____ year: _____
_____ year: _____ year: _____

Immunizations

Polio	Y N	Influenza	Y N
DPT	Y N	Hib	Y N
Tetanus	Y N	Hep B	Y N
Diphtheria	Y N	MMR	Y N
Pertussis	Y N	Chicken Pox	Y N
Adverse reactions?	Y N	If yes, what? _____	
Other: _____			

Family History

Does your child have a family history of any of the following conditions (please circle and note who)

Diabetes	Heart Disease	Arthritis	High Blood Pressure
Kidney Disease	Epilepsy	Glaucoma	Eczema
Tuberculosis	Stroke	Anemia	Alcoholism
Asthma	Allergies	Osteoporosis	Mental Illness
IBD	Cancer (please list type)		

Any other relevant family history? _____

Allergies

Is your child hypersensitive or allergic to... (please explain the type of reaction)

Any drugs? _____
Any foods? _____
Environmental allergens/chemicals? _____

Diet

Does your child follow a specific diet? Please explain: _____

Typical Food Intake:

Breakfast: _____
Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Current Medications and Supplements

Please list **any** prescription medications, over the counter medications, vitamins, or other supplements you are currently taking or use frequently. Include the dosage and potency.

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

Habits

Spend time outside daily?	Y	N
TV use (hours/day):	_____	
Reading (hours/day):	_____	
Computer use (hours/day):	_____	
Eat refined sugar?	Y	N
Drink soda?	Y	N

Review of Systems

Y = condition your child has now

N = never had

P = significant problem in the past

Mental/ Emotional

Treated for emotional problems?	Y	N	P	Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P	Mood swings?	Y	N	P
Irritability?	Y	N	P	Cries easily?	Y	N	P
Poor Concentration?	Y	N	P	Unusual fears?	Y	N	P
Hyperactivity?	Y	N	P	Eating Disorder?	Y	N	P
Sleep problems?	Y	N	P	Nightmares?	Y	N	P

Head

Headaches?	Y	N	P	Head injury?	Y	N	P
Migraines?	Y	N	P				

Eyes

Impaired vision?	Y	N	P	Glasses or contacts?	Y	N	P
Dryness?	Y	N	P	Eye pain/ strain?	Y	N	P

Ears

Impaired hearing?	Y	N	P	Ringing?	Y	N	P
Earaches?	Y	N	P	Frequent ear infections?	Y	N	P

Nose and Sinuses

Frequent colds?	Y	N	P	Nose bleeds?	Y	N	P
Sinus problems?	Y	N	P				

Mouth and Throat

Frequent sore throat?	Y	N	P	Frequent dental cavities?	Y	N	P
Hoarseness?	Y	N	P	Breath odor?	Y	N	P
Teeth grinding?	Y	N	P	Canker sores?	Y	N	P
Jaw/TMJ issues?	Y	N	P				

Neck

Lumps in neck?	Y	N	P	Difficulty swallowing?	Y	N	P
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Respiratory

Recurrent cough?	Y	N	P	Sputum?	Y	N	P
Asthma?	Y	N	P	Wheezing?	Y	N	P
Bronchitis?	Y	N	P	Shortness of breath?	Y	N	P
Pneumonia?	Y	N	P				

Cardiovascular

Heart disease?	Y	N	P	Congenital defect?	Y	N	P
Murmurs?	Y	N	P				

Gastrointestinal

Change in appetite?	Y	N	P	Nausea?	Y	N	P
Vomiting?	Y	N	P	Stomach aches?	Y	N	P
Constipation?	Y	N	P	Diarrhea/loose stools?	Y	N	P
Blood in stool?	Y	N	P	Motion/car sickness?	Y	N	P
Heartburn?	Y	N	P	# Bowel movements/day	_____		

Urinary

Increased urinary frequency?	Y	N	P	Bedwetting?	Y	N	P
Abnormal color/odor of urine?	Y	N	P	Frequency at night?	Y	N	P
Frequent urinary tract infections?	Y	N	P	Kidney disease?	Y	N	P

Male Reproductive

Hernias?	Y	N	P	Testicular Masses?	Y	N	P
Testicular pain?	Y	N	P				

Female Reproductive

Age of first menses?	_____			Nipple discharge?	Y	N	P
# of days between cycles:	_____	days		Vaginal pain?	Y	N	P
Duration of menstruation	_____	days		Vaginal itching?	Y	N	P
Are cycles regular?	Y	N	P	Vaginal discharge?	Y	N	P
Clotting?	Y	N	P	Breast tenderness?	Y	N	P
Cramping?	Y	N	P	Breast lumps?	Y	N	P
Bleeding between cycles?	Y	N	P	Nipple discharge?	Y	N	P
Heavy or excessive flow?	Y	N	P				

Immune

Chronically swollen glands?	Y	N	P	Night sweats?	Y	N	P
High fevers?	Y	N	P	Chronic infections?	Y	N	P

Endocrine

Heat intolerance?	Y	N	P	Excessive Hunger?	Y	N	P
Cold intolerance?	Y	N	P	Excessive Thirst?	Y	N	P
Low blood sugar?	Y	N	P	Fatigue?	Y	N	P

Musculoskeletal

Joint pain or stiffness?	Y	N	P	Muscle spasms or cramps?	Y	N	P
Broken bones?	Y	N	P	Weakness?	Y	N	P

Neurological

Seizures?	Y	N	P	Vertigo or dizziness?	Y	N	P
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Skin

Rashes?	Y	N	P	Eczema?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P
Color changes?	Y	N	P	Hives?	Y	N	P
Dry skin?	Y	N	P				

Blood/ Peripheral Vascular

Easy bleeding?	Y	N	P	Anemia?	Y	N	P
Easy bruising?	Y	N	P	Slow wound healing?	Y	N	P

Any information about your child's health that you would like to add? _____

Thank you. I look forward to helping your child in every way I can. If you have any questions please ask!

~ Dr. Van Dusen

Consent to Treatment

At Vital Source Natural Medicine we believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for them. Treatments at Vital Source Natural Medicine include such therapeutic procedures as manual soft tissue work, Craniosacral and Core Synchronism therapy, nutritional consultation and supplementation, herbal therapy, homeopathy, hydrotherapy, and lifestyle counseling. Other forms of treatment include intramuscular vitamin injections and certain pharmaceuticals. It is understood that while our practices and procedures are safe and effective, not everyone responds the same way to different treatments, and occasionally side effects or complications may arise.

While the risk of complications or side effects from any of the above treatments is very rare, it is our policy to inform our patients about them. These complications may include, but are not limited to: soreness, bruising, inflammation, burns, infection, allergic reactions, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

The way in which we choose to treat people will often be different than the conventional care of an MD. It is our policy to always present you with information about your condition, the procedure being performed, any risks, and alternative options available to you. If our explanation is not to your satisfaction, please ask for more information.

Please recognize that the care you receive at Vital Source Natural Medicine is voluntary. By signing this form, you are voluntarily consenting and authorizing our treatments and procedures. Please understand that you may refuse treatment and/or procedures at any time during your course of therapy and such requests will be respected.

By signing below, I acknowledge that I have read and understand the above statements regarding treatments and side effects. I understand that during my course of treatment at Vital Source Natural Medicine, I will be given an opportunity to ask questions about my condition. I will also be given the opportunity to ask questions regarding the benefits, risks, and alternatives to treatments offered. I understand that no guarantee has been made as to the result of my care at Vital Source Natural Medicine.

I hereby consent to examination and treatment with naturopathic medicine and/or Craniosacral and Core Synchronism therapy by Dr. Jessica Van Dusen at Vital Source Natural Medicine, PLLC.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

____/____/____
Date

Payment Agreement

Please read and **initial** the following statements. Feel free to ask if you have any questions about our policies.

_____ Payment for all services and medicinal items is due at the time of the visit. Payment may be made by cash, check, Visa, or MasterCard. Returned checks will be subject to a \$35.00 non-sufficient funds fee.

_____ You will be charged a missed appointment fee of \$35.00 for any missed appointments or late cancellations (less than 24 hours notice), emergencies excluded. If more than 1 appointment is missed or cancelled late, you will either be responsible for the full cost of the scheduled visit or will forfeit your right to re-schedule.

_____ You will be responsible for any additional expenses beyond office visits incurred in connection to your health care provided at Vital Source Natural Medicine. Such expenses may include postage, phone calls to our office wherein medical advice is provided to you (other than brief clarifying questions regarding your current treatment plan), or laboratory fees. If we make a payment for you, or on your behalf, you will need to reimburse the clinic promptly. You will always be informed of these charges in advance if/when this comes up.

I have read and understand the above-stated policies of Vital Source Natural Medicine, PLLC and will comply with them in all respects. If my insurance company requires release of my medical records for payment purposes, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

_____/_____/_____
Date

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care.

It is important that you understand that your information can be used and shared in the following ways:

- For your treatment (i.e. to contact you or to manage your care) and care coordination (multiple health care providers may be involved in your treatment directly and indirectly).
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease).
- In response to a court or administrative order.
- For research.
- To bill you or to obtain payment from third party payers.
- We may share your health information with a person(s) that *you have named* to be involved with your healthcare.

You have the following rights relating to your protected health information:

- To inspect your health record and receive a copy of your health record upon request.
- To request limits on the use or disclosure of your protected health information.
- To ask us not to share information with your health insurer regarding a service or health care item for which you have paid out-of-pocket in full.
- To choose someone to exercise your rights and make choices about your health information if you have named that person your medical power of attorney or if that person is your legal guardian.
- To request that your physician amend information in your health record you believe is inaccurate or incomplete.
- To receive an accounting of certain disclosures we have made, if any, of your protected health information.
- To receive a copy of this notice upon request.

You have the right to receive confidential communications from us by alternative means or at an alternative location if you choose.

Please tell us how to best contact you when needed:

___ Please do not phone me at home. Use this alternate phone number: _____

___ Please do not phone me at work. Use this alternate phone number: _____

___ Please do not leave messages on my voicemail.

___ Please do not contact me by email.

___ Please send mail, including my bills, to this alternate address: _____

___ Other request (please describe): _____

You can complain if you feel we have violated your rights by contacting us or you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

I give permission for Vital Source Natural Medicine to share my personal health information with the following person upon their request: Name: _____ DOB: _____ Relationship: _____

By signing below, I acknowledge that I have received and read this notice of privacy practices:

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

____/____/____
Date

E-Mail Agreement

Vital Source Natural Medicine may use e-mail to correspond with patients as a convenience. This includes appointment reminders and occasional clinic e-newsletters. Dr. Van Dusen and/or clinic staff will never initiate communication regarding personal health information over e-mail. Communication regarding lab results, changes to your treatment plan, or other matters pertaining to your healthcare will always take place over the phone unless you request otherwise. If you choose to ask questions regarding your treatment plan or health information via e-mail to Dr. Van Dusen, understand that this is not a secure way to do so.

I have been advised that:

E-mail is never, ever appropriate for urgent or emergency problems.

E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.

E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.

There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.

All e-mail correspondence will become a part of my medical record at Vital Source Natural Medicine. It is extremely important to include my name on each and every e-mail sent to the clinic.

Since e-mail may not be monitored while Dr. Van Dusen is out of the office, I will follow-up by telephone or in person if I do not receive a response within a reasonable time frame for the nature of my question.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.

I have been provided with information about the use of Internet e-mail communications between myself and Vital Source Natural Medicine, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting Vital Source Natural Medicine.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly: _____

Printed Name: _____

Signature: _____ Date: _____