Vital Source Natural Medicine
Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225
p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

Pediatric Intake Packet (birth to 5 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 ____

Does your child have a primary care pediatrician? Y / N

Name:_____

Reason for today's visit or chief complaint: _____

_____

Medications

Now	Past		Now	Past	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamines
____	____	Antibiotics	____	____	Other: _____
____	____	Ibuprofen			

Is your child currently taking any vitamins or supplements? Please list: _____

_____

Allergies

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

Any drugs? _____

Any foods? _____

Environmental allergens/chemicals? _____

Vital Source Natural Medicine
Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225
p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

Family History (please circle and name who/side of family)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Arthritis	Tuberculosis	Mental Illness	Eczema
Asthma	Allergies		

Any other relevant family history? _____

Immunizations

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

Medical History

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:	_____	
Other: _____					

Has your child had any of the following tests? Indicate **when** and **where** and **results**.

Electroencephalogram (EEG): _____

Psychological evaluation: _____

Hearing tests: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

_____

Exposures:

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

Is your child in daycare? Y / N

Diet

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

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Prenatal History

Previous pregnancies by natural mother, miscarriages, or complications? _____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy:

_____ Bleeding _____ Physical or emotional trauma _____ Nausea
_____ Illnesses _____ Medications _____ Hypertension
_____ Thyroid problems _____ Cigarettes, alcohol, drug consumption _____ Diabetes

Birth History

Pregnancy term: _____ Full _____ Premature _____ Late

Child's weight at birth: _____

Labor/delivery complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Colic _____ Seizures _____ Jaundice
_____ Fever _____ Rashes

Other:_____

Child's sleep patterns (1st year): _____

Food intolerances (if any): _____

Feeding: Breast fed? Y / N How long? _____ Formula? Y / N Type (milk/soy): _____

Age began solids: _____ Which foods? _____

Age began (if applicable): Sitting _____ Crawling _____ Walking _____ Talking _____

Symptoms

(Mark Y if current, P for past symptoms, leave blank if never)

_____ Hives _____ Vision problems _____ Cough
_____ Allergies _____ Nose bleeds _____ Breath/body odor
_____ Eczema _____ Frequent colds _____ Sensitive to light
_____ Chronic rash _____ Bleeding gums _____ Nervous
_____ Acne _____ Canker sores _____ Cries easily
_____ Headaches _____ Dental caries _____ Sleep problems
_____ Dizzy spells _____ Sore throats _____ Nightmares
_____ Hair loss _____ Wheezing _____ Unusual fears
_____ Hearing loss _____ Asthma _____ Heart murmur

Vital Source Natural Medicine
Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225
p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

_____ No appetite
_____ Jaundice
_____Stomach aches
_____ Motion/car sickness
_____ Gas
_____ Constipation
_____ Diarrhea
_____ Vomiting spells
_____ Frequent urination
_____ Bloody urine
_____ Burning of urine
_____ Bleeding tendency
_____ Easy bruising
_____ Anemia
_____High fevers
_____ Night sweats
_____ Excessive fatigue
_____ Flat feet
_____ Joint pains

Is there anything else you would like for me to know?

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

~ Dr. Van Dusen

Vital Source Natural Medicine

Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225

p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

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

Vital Source Natural Medicine

Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225

p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

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 medicinary 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

Vital Source Natural Medicine
Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225
p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

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

Vital Source Natural Medicine

Jessica Van Dusen, ND
1111 W. Holly St. Suite E
Bellingham, WA 98225

p: 360.306.8313
f: 360.306.8343
vitalsourcenaturalmedicine.com

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:_____