PARTNERS
IN HEALTH CARE
NATURALLY

*This is a confidential record of your medical history and will be kept in this office.*
*The information it contains will not be released to any person without your authorization.*

## PEDIATRIC INTAKE FORM (Ages 0 – 12)

Child's Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Cell: _____ Occupation: _____

Father's Name: _____ Cell: _____ Occupation: _____

Phone (Home): _____ Email: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Emergency contact: _____ Phone: _____ Relation: _____

Who is filling out this form? _____

With whom does the child live? _____ # of siblings: _____

Has your child ever had a massage and/or acupuncture treatment before? Yes ☐ No ☐
If yes, where and when? _____

Other health care professionals the child is seeing (ie. *Medical Doctor, Pediatrician, Chiropractor, other*)

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

How where you referred? _____

**Health Concerns**

Please list your child's health concerns in order of importance:

_____

_____

_____

Signature (person filling out this form): _____ Date: _____

Name of Child: _____

**Medical History**

Was your child adopted? yes ☐ no ☐ If yes, at what age? _____ What country? _____

List any injuries and/or major surgery your child has had and when they happened:

_____

_____

_____

_____

Has your child ever experienced any of the following?

☐ Rubella
☐ Mumps
☐ Measles
☐ Chickenpox
☐ Whooping cough
☐ Scarlet Fever
☐ Polio
☐ Rheumatic fever
☐ Diaper Rash
☐ Cradle cap
☐ Diarrhea
☐ Constipation
☐ High fevers
☐ Bedwetting
☐ Strep throat
☐ Frequent colds
☐ Stomach aches
☐ Headaches
☐ Heat or cold intolerance
☐ Ear infections:
How many? _____
How often? _____
☐ Other illnesses/diseases:
_____

**Vaccinations**

☐ DPT (Diptheria, Pertusis, Tetanus)
☐ MMR (Measles, Mumps, Rubella)
☐ Chickenpox
☐ Polio
☐ Flu shot
☐ Hepatitis A
☐ Hepatitis
☐ Other: _____

Did your child experience any adverse effects from vaccinations? If yes, please explain:

_____

_____

**Medications and Supplements**

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

_____

_____

_____

_____

Does your child have any medical allergies or sensitivities? Please list.

_____

_____

_____

_____

Name of Child: _____

**Family History**

Please **mark** if any close relative had any of the following health concern(s).

| | Mother | Father | Brother | Sister | Maternal grandmother | Maternal grandfather | Paternal grandmother | Paternal grandfather |
|---|---|---|---|---|---|---|---|---|
| Allergies | | | | | | | | |
| Diabetes | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Stroke | | | | | | | | |
| Heart Disease | | | | | | | | |
| Cancer | | | | | | | | |
| Seizure | | | | | | | | |
| Hepatitis | | | | | | | | |
| Kidney Disorder | | | | | | | | |
| Thyroid Disorder | | | | | | | | |
| Emotional Disorder | | | | | | | | |
| Systemic Lupus | | | | | | | | |

**Prenatal Health and History**

| | Health at conception | | | | Health throughout pregnancy | | | | Age at time of child's birth | # of previous pregnancies |
|---|---|---|---|---|---|---|---|---|---|---|
| Mother | Poor | Fair | Good | Excellent | Poor | Fair | Good | Excellent | | |
| Father | Poor | Fair | Good | Excellent | Poor | Fair | Good | Excellent | | |

Did the mother experience any food cravings/aversions during pregnancy? Yes ☐ No ☐ If yes, please list:

_____

Did the mother receive medical care during pregnancy? Yes ☐ No ☐ Unknown ☐

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Nausea ☐ Physical/Emotional trauma
☐ Vomiting ☐ Thyroid problems ☐ Other: _____
☐ High Blood Pressure ☐ Diabetes

Where any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Chorionic villi sampling ☐ Triple screen
☐ Amniocentesis ☐ Maternal serum screening ☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Vitamins or and/or supplements: _____

Signature (person filling out this form): Date:

Name of Child: _____

**Health and Development**

At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____

Where there any difficulties associated with teething? _____

Has your child experienced any pubertal changes? _____

**Nutritional History**

How is/was your infant fed? ☐ Breast fed ☐ Formula: Mild/Soy/Other: _____

For how long? _____

Did your infant experience any reactions to the breast mild or formula? Yes ☐ No ☐

If yes, please explain: _____

What foods were introduced **before 6 months**? Please list the approximate month and any reactions.

_____

_____

_____

Has your child ever experience colic? Yes ☐ No ☐

If yes, how severely? ☐ Mild ☐Moderate ☐ Severe

At what age and for how long? _____

Does your child have any food allergies or intolerances? Please list.

_____

_____

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)? _____

Does your child have any aversions to any foods? _____

Does your child have any environmental allergies or sensitivities? Please list.

_____

_____

**Sleep Patterns**

What time does your child usually go to bed? _____ Wake in the morning? _____

Does your child nap during the day? Yes ☐ No ☐ What time(s)? _____

Does your child have nightmares? Yes ☐ No ☐ How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

**Social Patterns**

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other: _____

What grade level? _____

Name of Child: _____

How would you describe your child's behavior at school? _____
_____
_____

How would you describe your child's behavior at home? _____
_____
_____

Does your child make friends easily? Yes ☐ No ☐

What are your child's interest & favorite activities? _____
_____

Is your child physically active regularly? Yes ☐ No ☐ How much & how often? _____
_____

Does your child have any habits (e.g. thumb sucking)? _____
_____

Does your child have any fears? _____

Approximately how much television does your child watch? _____ hours/day.

Does your child play on the computer or video games? Yes ☐ No ☐ If yes, _____ hours/week.

How often does your child read (not for school) or How often does someone read to your child?
☐ Daily ☐ Several times a weeK ☐ Weekly ☐ Less than weekly

**Environment**

Are there any pets in the home? Yes ☐ No ☐ What type and how many? _____

Does anyone in the child's household smoke? Yes ☐ No ☐

How is the child's home heated? _____

Do you use humidifiers in your home? Yes ☐ No ☐

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

Has your child ever had any significant physical or emotional traumas? _____
_____
_____

Signature (person filling out this form): _____ Date: _____

**THANK YOU**

# *Partners in Health Care, Naturally*

## Acknowledgement of Receipt of
## Notice of Privacy Practices for Protected Health Information

I, _____(print patient name), do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____

(Patient Signature) (Date)

In the event this request is made by the patient's representative/guardian:

_____

(Representative/Guardian) (Date)

_____

Partners in Health Care Naturally, Staff/Witness (Date)

# *Partners in Health Care, Naturally*

**Notice of Privacy Practices for Protected Health Information**
**Effective Date: January 1, 2012**

**This notice describes how medical information about you (as a patient) may be used and disclosed and how you can get access to this information.**
**Please review it carefully!**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (Protected Health Information, PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of this Notice of Privacy Practices that we have in effect at this time.

*We will provide you with the following important information:*
How we may use and disclose your PHI
Your privacy rights and your PHI
Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by Partners in Health Care, Naturally. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that Partners in Health Care, Naturally has created or maintained in the past, and for any of your records that we may create or maintain in the future. Partners in Health Care Naturally will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

If you have questions about this Notice, please contact:
Paula Sarvani, Front Office Coordinator, 928-445-2900

## We may use and disclose your PHI in the following ways:
## Treatment, Payment and Operations

### Treatment Purposes:

Partners in Health Care Naturally may use your PHI to treat you using laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may disclose your information to a pharmacy when we order a prescription for you. Those who work for our practice – including, but not limited to, our doctors and staff— may use or disclose your PHI in order to treat you or to assist in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

**Payment Purposes:**

Partners in Health Care, Naturally, may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We may contact your insurance company to verify eligibility of benefits. We may also provide details regarding treatment given to receive such payment. We may disclose to third party, such as family members that may be responsible for such costs. We may use your PHI to bill you directly for services and items rendered and will assist other health care providers and entities in their billing and collection efforts, such as labs.

**Health Care Operations:**

Partners in Health Care Naturally may use and disclose your PHI to operate our business. Examples, for our operations; our practice may use your PHI to evaluate the quality of care you received from us, quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance.

## Your Health Information Rights

**The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:**

• Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital — we are not required to grant the request, but we will comply with any request granted;
• Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
• Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
• Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering the request to our office;
• Appeal a denial of access to your protected health information, except in certain circumstances;
• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office/hospital;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
• Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.
• Elect to opt out of receiving farther communications from the office or via e-mail.

If you want to exercise any of the above rights, please contact Paula Sarvani, 343 S. Montezuma; 928-445-2900, in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

## Our Responsibilities

**Partners in Health Care, Naturally is required to:**

• Maintain the privacy of your health information as required by law;
• Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
• Abide by the terms of this Notice;
• Notify you if we cannot accommodate a requested restriction or request; and,
• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

## Other Disclosures and Uses

**Communication with Family**
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

**Notification**
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Disaster Relief**
We may use and disclose your protected health information to assist in disaster relief efforts.

**Food and Drug Administration (FDA)**
We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

**Workers Compensation**
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Public Health**
As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

**Abuse & Neglect**
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Employers**
We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization.
for the release of that information to your employer.

**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

**Serious Threat**
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

**For Specialized Governmental Functions**
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

**Coroners, Medical Examiners, and Funeral Directors**
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.

**Other Uses**
Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

**Website**
If we maintain a website that provides information about our entity, this Notice will be on the website.

## To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:
Paula Sarvani, Front Office Coordinator, 928-445-2900

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Dr. Susan Godman.**

# *Partners in Health Care, Naturally*

*343 S. Montezuma St. Prescott, AZ 86303*
*Phone:(928) 445-2900 Fax:(928) 445-2053*

**Consent to Treat**

Name: _____

Date of Birth: _____

I understand that this is a Naturopathic Medical Clinic and I give consent to this form of treatment. I understand that a Naturopathic Doctor is a physician who specializes in natural medicine. I am aware that with the guidance of the doctor, I may choose to be an active partner in helping determine my treatment plan and I will ask the doctor to explain when there may be a treatment that I am unfamiliar with or do not understand. I am aware that any type of medicine, conventional or otherwise, may have potential side effects. I will inform the doctor of any known allergies and provide previous medical history as necessary.

I hereby request Naturopathic Medicine treatment and therapies, including nutritional consultations and other procedures, including various modes of physiotherapy, nutritional therapy (including IV or IM injections if indicated) and diagnostic procedures, including laboratory testing, on me (or the patient named below for whom I am legally responsible) by a Doctor of Naturopathic Medicine and/or licensed doctors of Naturopathic Medicine who now or in the future treat me while employed by, working or associated with, or serving as back-up doctor in the offices of Partners in Health Care, Naturally. I also understand that Naturopathic Interns working under the doctor's direct supervision or the RN employed by the doctor may be directed by the doctor to perform certain diagnostic or therapeutic procedures on me during the time of my care.

Printed Name of Patient: _____

Patient/Guardian Signature: _____

Date: _____

**Financial Agreement**
I claim full financial responsibility for services rendered by Partners in Health Care, Naturally and understand that full payment is required at the time of service.

Signature: _____

Date: _____

**Cancellation/ No Show Policy**
I understand that Partners in Health Care, Naturally requires a 24-hour cancellation notice for all appointments. I understand that my failure to furnish notice will result in a charge of $45, which must be paid in advance of making a replacement appointment.

Signature: _____

Date: _____