ANGELA LONDON, ND
17639-100th Ave SW, Vashon, WA 98070 • phone (206)463-3696 fax (206)463-4576

Pediatric Intake

Please fill out both sides of this form

Name:_____

Wishes to be called: _____

Date: _____

Date of birth: _____

Parent/Guardian:_____ Parent/Guardian (2):_____

Address: _____ Email address:_____

City, State, Zip: _____

Referred by:_____

Contact Information: Parent /Guardian Responsible for the Account: _____

Employer:_____ Occupation: _____

Date of birth: _____ Social Security #: _____

Home Phone: _____ Pharmacy Phone:_____

Work Phone: _____ Cell Phone: _____

Where do you prefer to receive calls? Home Work Cell phone

Is it okay to leave a message? Yes No

In case of emergency, who should we contact? Name:_____

Relationship:_____ Work #: _____ Home#: _____

Insurance Information

Insurance Company: _____ *We will make a photocopy of your insurance card.*

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc, for services rendered at this location. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize London Health Center, Inc., to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I acknowledge that a portion or all of my child's care may not be covered by my insurance provider under the terms of my policy. The portions of my child's care that may not be covered may include, but are not limited to: deductibles, co-payments, and supplements.

X _____

Signature of parent or guardian Date

Thank you for filling out this form completely. The information you have provided will help us serve your health care needs more effectively and efficiently. If you have any questions at anytime, please ask. We are always happy to help.

A photocopy of these assignments shall be as valid as the original.

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Health Questionnaire Pediatric

Please fill out both sides of this form

Name:_____ Date of Birth: _____

Reason for visit: _____

Has parent or guardian ever consulted a Naturopathic Physician before? Yes No

FAMILY HISTORY

ADOPTED? YES NO If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CIRCLE THE # AND INDICATE RELATIVE

1) ALCOHOLISM	4) ASTHMA	7) ECZEMA	10) MENTAL ILLNESS
2) ANEMIA	5) ALLERGIES	8) HEART DISEASE	11) MIGRAINE
3) ARTHRITIS	6) CANCER (SPECIFY)	9) HYPERTENSION	12) TUBERCULOSIS

OTHER:

FATHER	Living? YES NO		MOTHER	Living? YES NO		Primary guardian(s):
BROTHERS	# Alive:	# Deceased:	SISTERS	# Alive:	# Deceased:	

HOSPITAL ADMISSIONS • PREGNANCY • DIET

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

Mother's age at child's birth:_____

Mother's health during pregnancy: Bleeding Nausea hypertension diabetes cigarettes, alcohol, drugs Illness Thyroid problems Physical or emotional trauma

How often do you eat organic foods? Always Frequently Occasionally Never

What foods do you exclude from your child's diet?

IMMUNIZATIONS AND MEDICATIONS *check the appropriate box and indicate # of times if indicated*

Vaccines: MMR Polio DPT HIB Influenza Hep B Chicken Pox

Medications: Antibiotics # Anti-histamine Aspirin # Decongestants # Inhalers Tylenol # Topical Steroids Others

ALLERGIES TO MEDICATIONS (please list)

MEDICAL HISTORY Mark 'C' for current problems and 'P' for past problems

Chicken pox	Blood in urine	Asthma/wheezing	Acne	Behavioral problems
Measles	Cough/croup	Eczema/rash	Anemia	Dizzy spells
Mumps	Freq headaches	Hives	Body/breath odor	Epilepsy
Rubella	High fevers	Constipation	Easy bruising	Cries easily
Scarlet fever	Hearing loss	Diarrhea	Fatigue	Nervous
Whooping cough	Jaundice	Gas	Canker sores	Sleep problems
Bronchitis	Night sweats	No appetite	Heart murmur	Sensitive to light
Pneumonia	Pain with urinating	Stomach aches	Joint pains	Nightmares
Frequent colds	Sore throats	Vomiting spells	Nose bleeds	Unusual fears
Tonsillitis # of times:		Ear infections # of times:		Other:

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

X_____

Signature of parent or guardian Date