Natural Medicine of NH, LLC

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Patient Note:This is a confidential record of your medical history. It will not be released except with your authorization. *Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark.*

New Patient Intake Form- Pediatric

Date:________________

Patient's Name:____

Age:____ Date of Birth:______/______/________ sex: female male

Mother's name:__________________________ Father'sname:____________________________

Legal guardian name if applicable____

Address:____

City:________________________________ State:_____ Zip____________

Home Phone (_____)___________________ Work Phone(_____)___________________

How did you hear about this clinic? ____

Does your child have a contagious disease at this time? Y or N

If yes, what? ____

Medical Concerns – What are the top concerns that you would like addressed?

1) ____

2) ____

3) ____

Previous Illnesses

___ Rheumatic fever ___German measles ___Measles ___Tonsillitis: approx. #______
___Ear infections: approx. number _______
□ Other: list_________________________________

Has your child had any of the following tests?

Electroencephalogram (EEG): **Y or N**
Psychological evaluation: **Y or N**
Hearing tests Speech/Language tests: **Y or N**

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

____

____

Immunizations

___Polio ___ Pertussis ___Tetanus shot ___Diphtheria
___ Measles/Mumps/Rubella ___Influenza ___Chicken pox

Any adverse reactions? **Yor N** If yes, what?___________________________________

Allergies

Is your child hypersensitive or allergic to any drugs? **Y or N Please list below**

Any foods? **Y or N**
Anything environmental? **Y or N**
Breast fed? ____ How long? _____ Formula? ____ Milk / soy

Typical Food Intake

Breakfast:____
Lunch:____
Dinner:____
Snacks:____
To Drink:____

Please list any prescription medications, over the counter medications, vitamins or other supplements
your child is taking.

1)____________________________________
2)_____________________________________
3)____________________________________
4)_____________________________________
5)____________________________________
6)______________________________________

REVIEW OF SYSTEMS

Y *= a condition now* ***P*** *= a condition in the past* ***N*** *= never had*

MENTAL/ EMOTIONAL

Mood Swings....................Y P N
Irritability...........................Y P N
Hyperactivity.....................Y P N
Introvert/extrovert.............Y P N
Nightmares.......................Y P N

Anxiety/nervousness.......Y P N
Cries easily.......................Y P N
Unusual fears................. Y P N
Sleep problems.................Y P N
Motion/car sickness..........Y P N

ENDOCRINE

Heat/cold intolerance........Y P N
High blood sugar………...Y P N
Excessive hunger.............Y P N

Fatigue.............................Y P N
Excessive thirst................Y P N
Low blood sugar……….. Y P N

SKIN

Rashes............................Y P N
Acne, Boils.................... Y P N
Eczema, Hives................Y P N
Itching..............................Y P N

HEAD

Headaches.......................Y P N
Dizzy spells.................... Y P N
Head Injury.......................Y P N
High fevers.......................Y P N

EYES

Glasses or contacts..........Y P N
Eye pain/strain................ Y P N
Tearing or dryness............Y P N

EARS

Earaches..........................Y P N
Impaired hearing.............Y P N

NOSE AND SINUSES

Frequent colds..................Y P N
Stuffiness.......................Y P N
Sinus problems.................Y P N
Nose Bleeds.....................Y P N
Hayfever...........................Y P N
Loss of smell..................Y P N

MOUTH AND THROAT

Frequent sore throat.........Y P N
Breath odor..................... Y P N
Canker sores....................Y P N

RESPIRATORY

Cough..................Y P N
Asthma................Y P N
Wheezing.........................Y P N
Bronchitis.........................Y P N

CARDIOVASCULAR

Heart disease...................Y P N
Murmurs...........................Y P N

URINARY

Frequent urination............Y P N
Bed wetting.......................Y P N

GASTROINTESTINAL

Belching/passing gas.......Y P N
Constipation.................... Y P N
Bowel Movements............Y P N
Stomach aches.................Y P N
Diarrhea............................Y P N
How often:________________

MUSCULOSKELETAL

Joint pain/stiffness............Y P N
Broken bones....... Y P N
Muscle spasms/cramps....Y P N

BLOOD/PERIPHERAL VASCULAR

Anemia............................Y P N
Easy bleeding/bruising.....Y P N

Is there any information about your child’s health that you would like to add?

____

____

Informed Consent

I acknowledge that I have been informed and understand that:

- Any education, advice or health plans provided to me as a client of Natural Medicine of NH LLC are **not** to replace medical care that I am receiving from another licensed health care provider or medical doctor.
- Natural Medicine of NH LLC strongly recommends that I am an active patient of a licensed primary care provider.
- I consent to treatment as agreed upon between Dr. Klasman and myself.
- Any therapy will proceed only with our mutual consent.
- I agree to discuss any concerns in my care with Dr. Klasman

Signature ________________________________ **Date:** ________________
(Patient or Parent / Legal Guardian)

Print Name of patient ____

Payment of Services

I agree to pay for any fees for service, costs of supplements, and remedies at time of service. Current fee schedule is as follows:

First Office Consult, New Patient: Fee $350 **Time of Service: $315**

This fee covers the first time a patient is seen by Dr. Klasman. It includes pertinent physical exams, possible lab test to be ordered (fee for labs is separate) and is approximately 90 minutes in length.

Return Office Consult: fee $175 **Time of Service $150**

This fee covers follow-up appointments with Dr. Klasman. It is approximately 45 minutes in length

Missed Appointment: **$100 or Full Service Fee**

We reserve the time you scheduled specifically for you, and the doctor takes time to prepare for your visit. This is time that is now unavailable to other patients. We require that any cancellation or change in your appointment be made 48 hours in advance. Patients that cancel or reschedule with less than 48 hours' notice will be charged a fee of $100. This includes cancellation messages left on our answering machine during or after hours less than 48 hours (2 full business days) before your appointment. A "no show" without notification may be charged the full cost of the visit. Note: If utilizing medical health insurance, this cannot be billed to your insurance company

I have read the above information and consent to pay for services rendered at the time of service and agree to the conditions and fees for missed appointments.

Signature ________________________________ **Date:** ________________
(Patient or Parent / Legal Guardian)

Print Name of patient ____