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) __________________________________ 4)___________________________________
5) __________________________________ 6) ___________________________________

Previous Illnesses
___ Rheumatic fever ___German measles ___Measles
___Tonsillitis: approx. number ______
___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
Eczema, Hives................Y P N
Acne, Boils.................... Y P N
Itching..............................Y P N

HEAD

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

EYES

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

EARS

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

NOSE AND SINUSES

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

MOUTH AND THROAT

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

RESPIRATORY

Cough..................Y P N
Wheezing........................Y P N
Asthma................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
Stomach aches................Y P N
Constipation.................... Y P N
Diarrhea............................Y P N
Bowel Movements...........Y P N
How often:________________

MUSCULOSKELETAL

Joint pain/stiffness...........Y P N
Muscle spasms/cramps....Y P N
Broken bones....... 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 and understand 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 agree to pay for any fees for service, costs of supplements, and remedies at time of service.

First Office Call, New Patient: Fee $250
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 one and one half hours in length.

Return Office Call: fee $125
This fee covers successive appointments with Dr. Klasman. It is up to one hour in length.

Missed Appointment: fee $50
We do understand that there may be extenuating circumstances; however, we do request that any cancellation or change in your appointment be made 48 hours in advance. Patients that do not keep appointments or cancel with less than 48 hours notice will be charged a fee. This includes cancellation messages left on our answering machine after hours, a day or two before your appointment.

I have read the above information and consent to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures and medications before they occur or are prescribed, and include that information in the decision regarding my healthcare. 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 ____