801 W Main St, Suite 1C
Bozeman, MT 59715
Ph. (406) 219-3631
Fax (406) 760-1809
www.ElevateHealthMT.com

PEDIATRIC INTAKE FORM (6-17 YEARS)

Patient's Name:_____ **Date of Service**:_____
Date of Birth: _____ **Gender**: ☐ Female ☐ Male **Age**: _____
Parent/Guardian's Name(s): _____
Address:_____ City:_____ State: _____Zip:_____
Telephone (home): _____(Parent's work):_____
Parent's email address: _____
Have any other family member already been a patient at this clinic? ☐ No ☐ Yes _____
HOW DID YOU HEAR ABOUT THIS CLINIC?_____
Insurance Coverage:_____ *Name of Policy Holder*:_____
*Member ID Number:*_____*Group Number:*_____
Name of doctor's office/hospital/clinic where your child's health records are kept:_____

_____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? ☐ No ☐ Yes If yes, what? _____

_____

Birth city & state:_____ Birth weight:_____
Breast Fed: ☐ No ☐ Yes How long:_____ Formula: ☐ No ☐ Yes Type (milk, soy)_____

PREVIOUS ILLNESSES (Please check all that apply)

☐	Chicken Pox – age:	☐	Mumps – age:	☐	Tonsillitis - approx no. of times:
☐	Measles – age:	☐	Rubella – age:	☐	Ear infections - approx no. of times:
☐	Scarlet Fever – age:	☐	Pneumonia	☐	Strep throat - approx no. of times:
☐	Rheumatic Fever – age:	☐	Frequent Colds	☐	Other:

Is your child hypersensitive or allergic to:
Any drugs?_____
Any foods? _____
Any environmentals?_____

Has your child ever had any of the following?

	WHEN	WHERE	RESULTS
Electroencephalogram (EEG)			
Psychological evaluations			

Hearing test			
Speech/language tests			
Injuries/ surgeries/ hospitalizations (please list)			

IMMUNIZATIONS

	MMR – date:		Measles – date:		Mumps – date:		Rubella – date:
	DPT – date:		Diphtheria – date:		Tetanus – date:		Polio – date:
	Chicken Pox – date:		Small Pox – date:		H. Influenza – date:		The Flu – date:

Others:_____ Adverse reactions: ☐ No ☐ Yes If so, what?_____

_____

DIET - Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

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

1)	5)
2)	6)
3)	7)
4)	8)

REVIEW OF SYSTEMS

Y = yes/condition you have now **N** = no/never had **P** = problem in the past **S** = sometimes a problem now

MENTAL/ EMOTIONAL					**SKIN**				
Mood Swings	Y	N	P	S	Rashes	Y	N	P	S
Irritability	Y	N	P	S	Eczema	Y	N	P	S
Hyperactivity	Y	N	P	S	Hives	Y	N	P	S
Introvert	Y	N	P	S	Acne	Y	N	P	S
Extrovert	Y	N	P	S	Boils	Y	N	P	S
Motion/car sickness	Y	N	P	S	Itching	Y	N	P	S
Anxiety/nervousness	Y	N	P	S	**NOSE AND SINUSES**				
Cries easily	Y	N	P	S	Frequent colds	Y	N	P	S
Unusual fears	Y	N	P	S	Nose Bleeds	Y	N	P	S

Sleep problems	Y	N	P	S	Stuffiness	Y	N	P	S
Nightmares	Y	N	P	S	Hay fever	Y	N	P	S
ENDOCRINE					Sinus problems	Y	N	P	S
Heat/cold intolerance	Y	N	P	S	Loss of smell	Y	N	P	S
Fatigue	Y	N	P	S	**EYES**				
Excessive thirst	Y	N	P	S	Glasses or contacts	Y	N	P	S
Excessive hunger	Y	N	P	S	Tearing or dryness	Y	N	P	S
Low blood sugar	Y	N	P	S	Eye pain/strain	Y	N	P	S
High blood sugar	Y	N	P	S					
HEAD					**EARS**				
Headaches	Y	N	P	S	Earaches	Y	N	P	S
Head Injury	Y	N	P	S	Impaired hearing	Y	N	P	S
Dizzy spells	Y	N	P	S	**CARDIOVASCULAR**				
High fevers	Y	N	P	S	Heart disease	Y	N	P	S
					Murmurs	Y	N	P	S
MOUTH AND THROAT					**GASTROINTESTINAL**				
Frequent sore throat	Y	N	P	S	Belching/passing gas	Y	N	P	S
Canker sores	Y	N	P	S	Heartburn	Y	N	P	S
Breath odor	Y	N	P	S	Stomach aches	Y	N	P	S
RESPIRATORY					Constipation	Y	N	P	S
Cough	Y	N	P	S	Diarrhea	Y	N	P	S
Wheezing	Y	N	P	S	Bowel Movements: How often?				
Asthma	Y	N	P	S	**URINARY**				
Bronchitis	Y	N	P	S	Frequent urination	Y	N	P	S
MUSCULOSKELETAL					Bed wetting	Y	N	P	S
Joint pain/stiffness	Y	N	P	S	**BLOOD/PERIPHERAL VASCULAR**				
Muscle spasms/cramps	Y	N	P	S	Anemia	Y	N	P	S
Broken bones	Y	N	P	S	Easy bleeding/bruising	Y	N	P	S

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

What expectations do you have for your child while working with our clinic?

WELCOME!
WE'RE HONORED TO BE OF SERVICE FOR YOU AND YOUR CHILD!

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CONSENT FOR TREATMENT

Description of Naturopathic Medicine: Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical exam may include more specific examination such as respiratory, cardiac, abdominal, musculoskeletal, neurological, gynecological, rectal, prostate or genital exams.

It is important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, and if you are on any medication, over the counter drugs or supplements. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Methods, Procedures and Therapeutic Approaches: These may include, but are not limited to: herbs/natural medicines, psychological and/or lifestyle counseling, homeopathy, exercise prescriptions, dietary advice, therapeutic nutrition, hydrotherapy, soft tissue, and physical manipulations. Please initial the following:

_____ Consent to Injections: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to **severe pain**, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Naturopathic medicine is a generally safe method of treatment, but may have some side effects. Risks include but are not limited to: pain, bruising, infection, loss of consciousness from needle

insertions (blood draw), topical procedures, and hydrotherapies; allergic reactions to prescribed medications, herbs or supplements; aggravation of pre-existing symptoms; and soft tissue or bone injury from physical manipulations.

Prescribed Supplements and Medications: The herbs, remedies and nutritional supplements recommended are traditionally considered safe, however some may be toxic in larger doses. The medications, herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. Please notify the doctor listed below immediately of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

Health Records: A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by you or your representative or otherwise permitted or required by law. You may arrange a time to look at your medical records during the clinic's business hours and can request a copy of it by paying the appropriate fee.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Bronwyn Bacon, ND, Elevate Health, or any of its personnel regarding cure or improvement of my condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient's Signature	Date	Guardian/Representative's Signature	Date

Print patients name	Relationship to Patient/Representative Authority

Naturopathic Doctor: Dr. Bronwyn Bacon, ND

NOTE THAT THIS FORM MUST BE SIGNED

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Acknowledgment of Responsibility for Payment and Payment Agreement

Welcome to the private practice of Dr. Bronwyn Bacon, ND. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

Payment: Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

Phone calls and emails: Phone calls and emails regarding an existing health issue that require more than 5 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Email replies that require more than 10 min of the doctor's time - $35. Phone calls are $45 per 15 min increment, billed in 15 min increments.

After hour calls: For non-life threatening health related emergencies you may reach your physician by calling the clinic and leaving a message marked "urgent" and stating you would like a call back. A $75.00 charge will be applied for pages to your physician. Additional charges maybe applied for additional services beyond responding to the page.

Late cancelations: We require 24-hour notice for canceling any appointments. There is a $75 charge canceled appointments if 24-hour notice is not given.

No shows: You will be charged the cost of any scheduled visit that you neglect to come to without a call to alert the clinic that you will not be able to make the visit. Special exceptions will be made for extenuating circumstances.

Supplements: Your health care provider may prescribe supplements, which may be purchased at the clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

Pharmacy prescriptions: Your health care provider may prescribe medications, which will be sent to the pharmacy of your choosing if possible. When you are due for a refill of these prescriptions please contact the pharmacy directly and they will send your doctor the refill request. A visit may be required for medication refill.

I have read and understand the above-stated policies of Dr. Bronwyn Bacon's clinic and will comply with them in all respects. I understand that I am financially responsible for the services provided to me by Dr. Bronwyn Bacon, N.D. LLC regardless of insurance coverage. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I also certify that I have read the Notice of Privacy Practices and understand that disclosure of my protected health information may be necessary to secure payment for health care services.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature Date

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct 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 and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds or in cases of abuse.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please circle all that apply:

Please write number in the space provided	May we contact you at this number?		Can we leave messages for you at this number?		Can we send text message reminders to this number	
Home:	Yes	No	Yes	No	Yes	No
Work:	Yes	No	Yes	No	Yes	No
Cell:	Yes	No	Yes	No	Yes	No
Other:	Yes	No	Yes	No	Yes	No

Email:_____
May we contact you at this email, including sending you appointment reminders? Yes No

Patient Name (Please Print and sign below where indicated. Include parent/guardian name if patient is a minor.)

_____ _____ _____
Patient's Signature Print Patient's Name Date

_____ _____ _____
Parent/Gaurdian Signature Parent/Guardian Name (if a minor) Date

_____
Relationship to patient

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Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Dr. Bronwyn Bacon, ND on this date.

_____ _____

Date Signature

_____ _____

Patient Representative's Signature Relationship to Patient

Patient unable to sign because:

_____

_____

PRINT NAME OF PATIENT

_____

Street Address

_____

City, State and Zip Code