LONDONHEALTHCENTER • 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 Fax (360) 384-2955

Pediatric Intake

Please fill out both sides of this form

Name:_____

Wishes to be called:_____

Date:_____

Date of birth:_____

Parent:_____ Other Parent or Guardian:_____

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: _____

Is it okay to leave a message? ☐ Yes ☐ No

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

Relationship:_____ Work #: _____ Home#: _____

Insurance Information

We will make a photocopy of your insurance card

Primary Insurance_____ **Subscriber's Name**_____ **DOB**_____

Secondary Insurance_____ **Subscriber's Name**_____ **DOB**_____

First Choice or Great West insurance only: Subscriber's Social Security #_____

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc. for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance, **including fees for pager services.**

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 or scanned copy of these assignments shall be as valid as the original.

LONDONHEALTHCENTER • 2376 Main Street Suite 3 • Ferndale, WA 98248 • (360) 384-2900 Fax (360) 384-2955

Health Questionnaire Pediatric

Please fill out both sides of this form

Name:_____ Date of Birth: _____

Reason for visit: _____

Has parent or guardian every 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 □ Small Pox □ Influenza □ Hep B □ Chicken Pox

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

ALLERGIES TO MEDICATIONS (please list medication and reaction)

□ No known allergies

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