

1 ABOUT THE CHILD

Last Name:	First Name:	MI	Date of Birth:	Age:	Social Security Number:
Mailing Address:			Height:	Weight:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip Code:			Best Way to Reach You: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Preferred Phone: ()	

2 ABOUT THE PARENT

Last Name:	First Name:	MI	Home Phone: ()	Cell Phone: ()
Address: <input type="checkbox"/> Same as Above	Mailing Address:	City, State, Zip Code:		
Employer Name:	Job Title:	Work Phone: ()		
Employer Address:		Employer City, State, Zip Code:		

3 VACCINATIONS/MEDICATIONS

Have you chosen to vaccinate your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, check all that your child has received: <input type="checkbox"/> DPT <input type="checkbox"/> MMR <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other			
Any reactions to vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Your Child Take Vitamins or Herbs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, List or <input type="checkbox"/> See Attached				

4 NATURAL HEALTH CARE EXPERIENCE

Who referred you to our office?	Have you seen or heard of our office because of (check all that apply)? <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Health Care Professional <input type="checkbox"/> Web <input type="checkbox"/> Other			
Has your child been seen by a natural health doctor before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was the reason for those visits?			
Doctor's Name:	Approximate date of last visit:			

5 REASON FOR THIS VISIT

Describe the reason for this visit: <input type="checkbox"/> Wellness <input type="checkbox"/> Condition	Is the purpose of this visit related to: <input type="checkbox"/> Digestion/Diet <input type="checkbox"/> Behavior <input type="checkbox"/> Sports	When did this condition begin?
Please describe your concerns:		
Has this condition: <input type="checkbox"/> Gotten Worse <input type="checkbox"/> Stayed Constant <input type="checkbox"/> Come and Gone	Does this condition interfere with: <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Other Activities	
Has the condition occurred before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did your child receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of doctor: Result:

7 PAYMENT AND INVOICING (payment is due at the time of service)

<input type="checkbox"/> Would you like a copy of your invoice emailed to you for you to submit to your insurance company?	<input type="checkbox"/> I understand that I must provide 24 hours notice to cancel or reschedule an appointment, and that if I do not, charges will still apply.
--	---

The information provided on this form is true to the best of my knowledge, and I will inform you of any changes in my health, demographics or insurance when applicable. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release information required to process my claims and that, otherwise, it will be kept confidential in accordance with state law.

Guardian Signature:	Date:	Email:
---------------------	-------	--------