PEDIATRIC NEW PATIENT PACKET

Welcome to our Clinic!

Name: _________________________________ Date: ___________________
Address: ____
City: ___________________ State: _______________ Zip Code: __________
Date of Birth:_______________ Age:__________ Gender: Female / Male
Height:______ Weight:_______

Parent/Guardian Contact Information:
Name ___________________________Relationship to child _________________
Address: ____
Home phone: (_____)______-_________ Cell phone: (_____)_____-________
E-mail: ______________________________

HOW DID YOU HEAR ABOUT US?
____

HEALTH HISTORY
What is the main reason for seeing the doctor today? If there is a specific health condition, please describe it in detail, including the first time you noticed the condition and anything you suspect played a role in its onset and continuation.
____
____
____
____

Please list other health conditions in order of importance:
1.)_________________________________Onset: ___________________
2.)_________________________________Onset: ___________________
3.)_________________________________Onset: ___________________

Dr. Heather Sorber, ND
1510 St. Helens Street, Suite C, Saint Helens OR 97051
Phone: 503-410-3134 Fax: 503-893-3118

How would you describe your child's overall state of health? (please circle one)

Excellent Good Average Fair Poor

Who is the child's pediatrician?
Name: ________________________________ Phone: ________________________

Has the child ever seen a naturopath, chiropractor, or acupuncturist before? Yes / No

ALLERGIES: List all drug, food and environmental allergies and the reaction to it:
____
____

PAST MEDICAL HISTORY
List any major illnesses with approx. dates: ____
____
List any surgeries or operations with approx. dates: __________________________________
____
Past accidents or injuries: ____
____

FAMILY HISTORY: Please list any medical conditions that run in your family (parents, siblings, grandparents, aunts and uncles): ____
____
____

MEDICATIONS/supplements/vitamins currently taking (please include dosage and how long the child has been taking it): ____
____
____

Typical food intake:

Breakfast:

Lunch:

Dinner:

Snacks/desserts:

Water in glasses or ounces:

Other beverages:

Birth History:

At how many weeks gestation was the child born? ____ Circle One: Vaginal / C-Section

How much did he/she weigh? _______ How long in inches? ________

Were there any birth complications? ____

Was the child breast fed? Y / N If yes, for how long? ________________________

Were there difficulties introducing any foods? Which ones? _______________________

Immunization History
Has the child had all immunizations? Y / N

Please circle all administered: Hep B DTap/DTP Hib Polio MMR

Varicella (Chicken Pox) Other ________________

Any reactions/complications from immunizations: ______________________________

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Clinic Policies

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Please **initial** that you understand and agree to the following statements:

________ **Payment Agreement**

Payment for all services, tests, and medicinary items (that are not covered by your insurance) are due at the time of service. We accept all credit cards. Returned checks will be subject to a $25.00 NSF fee.

________ **Product Returns**

We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. Once these products leave our office, we cannot bear responsibility for their storage or their use. For the health and safety of our patients, we cannot accept returns on any medicinary products.

________ **Cancellations and Missed Appointments**

If you are unable to make your scheduled appointment, please call the clinic at least **24-hours** in advance of your scheduled time. You will be charged a $40 missed appointment fee if you miss a scheduled appointment or fail to cancel at least 24-hours in advance.

______ **Email Correspondence**

The doctors at Columbia River Natural Medicine may use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow correspondence **by email** and to **other practitioners necessary for your care** in spite of these potential risks.

I have read and understand the above-stated policies and will comply with those I have initialed in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

____

Print Name   Signature of Patient/Guardian   Date

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Columbia River Natural Medicine, LLC

Informed Consent

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent to Treatment

The therapeutic procedures of naturopathic medicine are considered safe and effective methods of care. Any procedure intended to help may also have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them.

Please read and sign below that you understand the following procedures:

Nutritional supplements, herbs, and homeopathy may be used to aid in healing. Be sure to inform your practitioner about all medications you are taking to minimize drug/supplement interactions. If you believe you are experiencing any side effects from your supplements/herbs/homeopathy be sure to alert your health care provider.

____ Initial and circle if you have any severe food allergies to shellfish, gluten, soy, dairy, other ________________________.

Naturopathic Manipulation is a form of physical medicine. The practitioner uses gentle force to manipulate spinal segments or bones in the extremities to re-establish normal movement and function. Please alert your provider if you have previously had negative effects with naturopathic manipulation or chiropractic adjustments.

Applied Kinesiology is a safe and non-invasive natural method of analyzing the body's physical and nutritional needs. It is not a method of "diagnosing" or "treating" any particular disease.

I understand, and am informed that in the practice of medicine and naturopathy, there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read and understand the above statements and have had the opportunity to ask questions. I understand that the health improvement program recommended to me is not for the "cure" of any particular disease. No promise or guarantee has been made regarding the results of Applied Kinesiology, or any natural health, nutritional or dietary programs. Rather, the above will be used for bringing about a more optimum state of health. By signing this form you consent to the treatments provided by the doctor(s) practicing at Columbia River Natural Medicine.

____

Print Name | Signature of Patient/Guardian | Date

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act 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
- 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 **check all that apply**:

☐ Please do not phone me at home.
  Use this alternate phone number: ______________________

☐ Please do not phone me at work.
  Use this alternate phone number: ______________________

☐ Please do not call my cell phone.
  Use this alternate phone number: ______________________

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:

____

☐ Other request (please describe):

____

____

Print Name　　　　Signature of Patient/Guardian　　　　Date

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