HARMONY
FAMILY MEDICINE

Meghan Van Vleet, ND
Doctor of Naturopathic Medicine

Pediatric Patient Health History

Today's Date: _____

Patient's Name: _____
(Last) (First) (Middle)

Age: _____ Birthdate: _____ Gender assigned at birth: M F Gender identity: M F

Parent's Names: _____
(Mother) (Father)

Name of Gaurdian: _____

Living with: _____ Relationship: _____

Address: _____
(Street, City, State, Zip)

Mailing Address (if different): _____
(Street, City, State, Zip)

E-mail address: _____

Phone(s): _____
(Home) (Work) (Other)

School: _____

Grade in school: _____ School phone: _____

Emergency contact: _____
(Name) (Phone)

Relationship: _____

How did you learn about my practice? _____

Your child's primary care physician: _____
(Physician's Name)

Address: _____

Reason for today's visit: _____

_____

_____

Please list known ALLERGIES to medication, food, or environment: _____

_____

_____

MEDICATIONS

	Now	Past		Now	Past
Antibiotics	____	____	Ibuprofen	____	____

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	Now	Past		Now	Past
Decongestants	____	____	Aspirin	____	____
Anti-histamine	____	____	Tylenol	____	____
Inhalers	____	____	Insulin	____	____

Others: _____

List all current medications, dosage, and reason for taking (or attach a list)

_____

_____

List all current vitamins/supplements/herbs/homeopathics, dosage, and reason for taking (or attach a list)

_____

_____

MEDICAL HISTORY

Childhood illnesses (Y=yes, N=never, ?=not sure)

Measles (14-day Rubeola) ____
Mumps ____
Rubella (3-day German measles) ____
Chickenpox ____
Skin rashes ____
Frequent colds ____
Strep throat ____
Scarlet Fever ____
Rheumatic Fever ____
Herpes ____
Pneumonia ____
Tonsillitis ____
Ear Infections ____
Diabetes ____

Chronic diarrhea or constipation _____

Other (please list) _____

IMMUNIZATIONS

MMR (measles, mumps, rubella) ____
DPT (diptheria, pertussis, tetanus) ____
Polio ____
Chickenpox ____
Tetanus ____
Influenza (flu) ____
Hepatitis ____
Others (please list) _____

SURGERIES

Tonsillectomy ____
Ear tubes ____
Appendix ____

Other (please list) _____

SPECIAL EVALUATIONS

Has your child ever had any of the following exams or tests? Please state when, where, and results.

Hearing _____

Speech/language _____

Allergy testing _____

Psychological evaluation _____

Dental exam/cleaning _____

Vision check _____

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Other _____

FAMILY HISTORY (mother/father/siblings)

Heart disease ____
Hypertension ____
Diabetes ____
Depression ____
Birth defects ____
Allergies ____
Eczema ____
Rheumatoid arthritis ____
Thyroid problems ____
Bowel disorders ____
Tuberculosis ____
Cancer (type) _____

Mental illness (type) _____

Other _____

PRENATAL/BIRTH/NEONATAL HISTORY

Mother's health during pregnancy

Hypertension ____
Diabetes ____
Thyroid problems ____
Smoking, alcohol, drug use _____
Physical or emotional trauma _____
Illnesses _____

Medications _____

Mother's age at birth of child: _____

Term: Full ____ Premature ____ Late ____ Birth wt: _____lbs ____oz

List complications during labor or at birth: _____

_____

Neonatal complications (ie: colic, jaundice, heart murmur) _____

DEVELOPMENTAL HISTORY

Child's sleep pattern first year _____

Bed wetting _____

Breast Fed: Y N How long? _____ Formula: Cow milk ____ Soy ____ Other _____

Age solid foods introduced: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (Y=yes, P=past, N=never)

Frequent headaches	Y	P	N	Wheezing	Y	P	N
Dizzy spells	Y	P	N	Frequent cough	Y	P	N
Motion/car sickness	Y	P	N	Frequent vomiting	Y	P	N
High fevers	Y	P	N	Frequent diarrhea	Y	P	N
Siezures	Y	P	N	Freq. constipation	Y	P	N
Frequent colds	Y	P	N	Stomach aches	Y	P	N
Ear pain/itching	Y	P	N	Excessive gas	Y	P	N
Hearing loss	Y	P	N	No appetite	Y	P	N
Frequent sore throat	Y	P	N	Body/breath odor	Y	P	N
Nose bleeds	Y	P	N	Burning on urination	Y	P	N
Canker sores	Y	P	N	Frequent urination	Y	P	N
Bleeding gums	Y	P	N	Bloody urine	Y	P	N
Easy bruising	Y	P	N	Anemia	Y	P	N

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Easy bleeding	Y P N	Joint pain	Y P N
Excessive fatigue	Y P N	Flat feet	Y P N
Night sweats	Y P N	Cries easily	Y P N
Sensitive to light	Y P N	Nervous	Y P N
Hives	Y P N	Sleep problems	Y P N
Eczema	Y P N	Nightmares	Y P N
Chronic rash	Y P N	Unusual fears	Y P N
Acne	Y P N		

DIET

Please describe your child's typical daily diet.

Glasses of water/day: _____

Breakfast: _____

Lunch: _____

Snacks/beverages: _____

Dinner: _____

Does your child have any food intolerances that you know of? Y N

If yes, please explain: _____

_____

Informed Consent

Naturopathic Doctors are registered by the state to practice naturopathic medicine under the "Naturopathic Doctor Act". They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than B-12, B-6, epinipherine, topical anesthetics, and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device; however the removal of surface lesions and suturing of the skin is permissible.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Treat a child, unless
    - An informed consent for treatment is completed and signed.
    - The most recent immunizations schedule recommended by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services is provided to the parent or guardian with this form.
    - A release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric healthcare provider, if the child has one.
- Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine.
- Practice obstetrics.
- Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine as described in 12-37.3-102(12)(b), C.R.S., is permitted
- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

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Because there are services that a Naturopathic Doctor can not provide it is recommended that you also have a relationship with a licensed physician or a licensed pediatrician (if under the age of 8). If you need a referral, I would be happy to provide one. Naturopathic Doctors are one part of the Colorado Health Model and as such we often collaborate with other healthcare professionals. We will work to develop and maintain collaboration with your physician in order to provide you the best possible care.

As a patient of a Naturopathic Doctor your experience at the office may include an intake, appropriate exams and diagnostic tests, collaboration with your other healthcare providers and treatment that may involve but is not limited to any of the following modalities:

- Nutritional Supplementation
- Dietary and Nutritional Recommendations
- Botanical Medicine
- Hydrotherapy
- Naturopathic Physical Medicine
- Minor Office procedures to include but not limited to sutures for lacerations and removal of cysts.
- Administration of approved vitamins and medications
- Counseling

Disclosure Statement

1. I, Meghan Van Vleet, ND, am a Naturopathic Doctor registered under Title 12, Article 37.3, of the Colorado Revised Statutes.
2. I am not a medical doctor or a physician licensed under Title 12, Article 36, of the Colorado Revised Statutes.
3. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric healthcare provider.
4. If the patient is a child aged two to seven, I recommend that the child's parent or guardian follow the immunization schedule that accompanies this form.
5. If the patient has a relationship with a licensed physician or pediatric healthcare provider, I will attempt to develop and maintain a collaborative relationship with the physician or pediatric healthcare provider. To permit this, the patient (or patient's parent/guardian if patient is a minor) will need to sign a separate release allowing me to exchange information with the licensed physician or pediatric healthcare provider.
6. **PWCB Disclaimer:** As a patient of Harmony Family Medicine PLLC at the Postpartum Wellness Center of Boulder, I understand that I am receiving treatment at a facility that works toward comprehensive and collaborative care whenever possible in an effort to provide best-practice treatment to its patients. I understand that my case may be discussed in collaborative care consultations with other clinicians at the PWCB. I understand that by signing this document, I give Meghan Van Vleet, ND, RND permission to address my case in these meetings when necessary.

_____ _____

Naturopathic Doctor Signature Date

By signing this informed consent I hereby acknowledge receipt of the above disclosure statement and give my informed consent to being a patient and receiving treatment.

_____

Patient Printed Name

_____ _____

Patient (Parent/Guardian) Signature Date

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