Amanda H. Fey, ND Complementary Medicine and Healing Arts
27 Jenison Ave, Johnson City, NY 13790, ph. 607-729-0591

Hello and Welcome!

Attached you will find pediatric intake forms. Before your child's scheduled appointment, please fill out the forms as thoroughly as possible. I know your time is valuable and by bringing your already completed intake forms with you will maximize the time spent at your health visit.

Your child's first visit will consist of a thorough assessment of his/her health history lasting between 45 minutes to an hour. *Please bring copies of any recent lab work, as well as any supplements or medications your child is currently taking.*

If you are unable to keep your child's scheduled appointment for any reason, please let us know so we can reschedule his/her visit at a more convenient time. A 24-hour notice is greatly appreciated.

I truly look forward to working with you and your child on the journey towards optimal health.

Warmly,
Amanda H. Fey, ND

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NEW PEDIATRIC INTAKE FORM (0-12 years old)

Date_____ Child's name_____

Date of Birth_____ Age_____ Gender: Male or Female

Address:_____
STREET OR PO BOX CITY, STATE, ZIP

Phone: Home_____ Work/Cell_____

Mother's Name:_____ Father's Name: _____

If parents are separated, child primarily lives with:_____

Emergency contact-name, phone, relationship_____

How did you hear about our clinic?_____

HEALTH HISTORY

What are your child's most important health concerns? List them in order of importance

1._____ Date of Onset_____

2._____ Date of Onset_____

3._____ Date of Onset_____

4._____ Date of Onset_____

5._____ Date of Onset_____

Is your child currently receiving healthcare for his/her concerns? □ Yes □ No
If yes, where and from whom?_____

If no, when and where did you last receive medical or health care? What was the reason?

_____

Previous Hospitalizations/Surgeries Reason Date

_____

_____

_____

How would you describe your child's overall state of health (please circle)?
Excellent Good Average Fair Poor

PREVIOUS ILLNESSES

Measles	Y	N	Rheumatic Fever	Y	N
Chicken Pox	Y	N	Rubella	Y	N
Mononucleosis	Y	N	Tonsillitis	Y	N
Mumps	Y	N	Ear Infections	Y	N
Pneumonia	Y	N	Seizures	Y	N

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ALLERGIES

Does your child have any allergies to drugs, food, or to the environment (animals, dust, mold, etc)
□ No □ Yes If yes, please indicate what allergies and how he/she was tested:

_____

VACCINATIONS

□ Diptheria □ Measles/Mumps/Rubella □ Pertussis □ Chicken Pox
□ Tetanus □ Hepatitis B □ Polio □ Pneumococcal
□ HiB □ Influenza □ Other_____

TYPICAL FOOD INTAKE

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Breast fed?_____ How long?_____Formula (type)?_____

Were there any trouble introducing foods as infant? If yes, which foods and what were the

difficulties?_____

CURRENT MEDICATIONS

Please list all current prescription medications and over the counter medications:

1. _____Dose_____Indication_____

2. _____Dose_____Indication_____

3._____Dose_____Indication_____

4._____Dose_____Indication_____

How many courses of antibiotics has your child had in the past 10 years?_____

CURRENT SUPPLEMENTS

Please list all current supplements including herbs, vitamins, and/or other supplements:
1. _____Dose_____Indication_____

2. _____Dose_____Indication_____

3._____Dose_____Indication_____

4. _____Dose_____Indication_____

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FAMILY HISTORY

Please indicate if any family member has/had any of the following:

	Family member		Family member
Cancer	_____	Autoimmune Disease	_____
Heart Disease	_____	Asthma/Allergies	_____
Diabetes	_____	Alcoholism/Addictions	_____
Depression/Anxiety	_____	Hypertension	_____
Mental Illness	_____	Bleeding disorders	_____

REVIEW OF SYSTEMS

N = Now **P = Past**

MENTAL/EMOTIONAL					
Irritability	N	P	Mood swings	N	P
Anxiety/nervousness	N	P	Hyperactive	N	P
Poor concentration	N	P	Unusual fears	N	P
Sleep problems	N	P	Nightmares	N	P
Cries easily	N	P	Introvert/Extrovert	_____	
SKIN					
Rashes	N	P	Acne or Boils	N	P
Itching	N	P	Eczema/Hives	N	P
HEAD					
Headaches	N	P	Dizzy spells	N	P
Head Injury	N	P	High Fevers	N	P
EYES					
Glasses or contacts	N	P	Tearing or dryness	N	P
Eye pain/strain	N	P			
EARS					
Impaired hearing	N	P	Earaches	N	P
NOSE & SINUSES					
Frequent Colds	N	P	Nose Bleeds	N	P
Hay fever	N	P	Stuffiness	N	P
Sinus Problems	N	P	Loss of Smell	N	P
MOUTH & THROAT					
Frequent sore throat	N	P	Canker sores	N	P
Bleeding gums	N	P	Breath odor	N	P
RESPIRATORY					
Cough	N	P	Asthma	N	P
Wheezing	N	P	Bronchitis	N	P
CARDIOVASCULAR					
Heart Disease	N	P	Murmurs	N	P
GASTROINTESTINAL					
Diarrhea	N	P	Constipation	N	P
Belching/ Gas	N	P	Stomachaches	N	P
Bowel Movements:	How many/day?_____		Is this a change?_____		
URINARY					
Frequent urination	N	P	Kidney stones	N	P
Frequent infections	N	P	Bed wetting	N	P
MUSCULOSKELETAL					
Joint pain/stiffness	N	P	Muscle spasm/cramps	N	P
Broken bones	N	P			
BLOOD/PERIPHERAL VASCULAR					
Easy bruising/ bleeding	N	P	Anemia history	N	P

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ENDOCRINE

Heat/ cold intolerance	N	P	Low blood sugar	N	P
Excessive thirst	N	P	Excessive hunger	N	P
Fatigue	N	P	High blood sugar	N	P

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

_____

_____

_____

Payment Policy Agreement

By signing below, you understand that full payment for all services and products you receive from Amanda H. Fey, ND is required at the time of service. MasterCard, VISA, Debit cards, checks, and cash are accepted. You understand that there will be a $20.00 charge for each returned check. You understand that you will be charged a fee of $50 for any missed appointments or any cancellations less than 24 hours ahead of your scheduled visit.

Consent Form and Agreement

By signing below, you recognize and understand that Amanda H. Fey, ND is a Doctor of Naturopathic Medicine licensed in the state of Oregon; and therefore, is not licensed to practice medicine in the state of New York. Further, you recognize and understand that she does not diagnose, write, or change pharmaceutical prescriptions. Nutrition and natural health services do not replace the role of a conventional physician. Amanda H. Fey, ND is using her education and experience to give you suggestions about your health. You assume the responsibility for the decision to use a natural remedy. If you feel that you are experiencing any adverse reactions then you understand to stop all supplements immediately.

Signature of Patient or Guardian:_____Date:_____

Printed Name:_____

Notice of Privacy Practices

By signing below, you give permission to the staff at Complementary Medicine and Healing Arts to contact you by telephone and they may leave a message that may contain appointment or medical information if you are not available. You understand that you have the right to inspect and/or copy your health information. Requests to disclose your health information to another health care provider should be provided in writing, unless it is an emergency situation.

Signature of Patient or Guardian:_____Date:_____

Printed Name:_____