LAKESIDE HOLISTIC HEALTH, PLLC

New Patient Intake Packet ~ Child

The information you provide here helps the provider understand your child's physical, mental, and emotional condition more completely in order to help you attain your health goals. Please answer all the questions as completely as possible.

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ___M ___F Child lives with: Father ___ Mother ___ Both ___ Other ___

Mailing Address: _____ City/State/Zip: _____

Mothers Name: _____ Phone Number: _____

Fathers Name: _____ Phone Number: _____

Other Guardian: _____ Phone Number: _____

May we leave a detailed message? ___ Y ___ N

Email: _____

May we send you email appointment confirmations? ___Y ___N

Would you like to join our Platinum Wellness Club & receive our monthly newsletter? ___Y ___N

How did you hear about Lakeside Holistic Health, PLLC?

___ Personal Referral: Please provide their name so we may thank them: _____

___ Business Referral: Please provide their name so we may thank them: _____

___ Website ___Facebook ___Insurance: _____ ___ Print Ad: Which one? _____

Patients Pediatrician: _____ Date of last Examination: _____

Patients School: _____ Birthplace: _____

Purpose for this appointment:

PERSONAL HEALTH

Blood Type: _____

Birth History / Delivery

Normal	Vaginal	Forcep	Vacuum	Breech	Cesarean

Any Complications during delivery?

Where was your child born?		
Home:	Hospital:	Birth Center:

Any Complications during Pregnancy?

Was your child breastfed? (Please document yes or no. If yes, please explain how long.)

Vaccination History

DTap (diphtheria, tetanus, pertussis)	MMR (measles, mumps, rubella)	DT	Hepatitis	Tetanus	Pneumococcal conjugate	MCV4 (Meningococcal)	HIB (Haemolphilus influenzae B)	Varicella (chicken pox)
Specify Other:								
Any Reactions?								

Has your child had any of the following childhood illnesses? Mark Y or N

Asthma	Ear Infection	Chronic Colds	Food Allergies	Digestive Problems	Chronic Cough	Failure to Thrive	Colic	Seizures	ADD/ ADHD
Hives/ Rashes	**Eczema/ Psoriasis**	**Recurring Fevers**	**Headache**	**Growing/ BackPain**	**Scoliosis**	**Mood Swings**	**Bed Wetting**	**Sinus Problems**	**Infections**
Specify Other:									

CHILD NEURO & NUTRITION QUESTIONNAIRE

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Section A	0	1	2	3
Does your child eat pasta, breads, and breaded foods?				
Does your child have symptoms (fatigue, hyperactivity, etc) after eating wheat?				
Does your child eat dairy products?				
Does your child have symptoms (fatigue, hyperactivity, etc) after eating dairy?				
Section B	**0**	**1**	**2**	**3**
Does your child eat fried fish?				
Does your child eat roasted nuts or seeds?				
Is your child missing essential fatty acid rich foods?				
(Example: avocados, flax seeds, olives)(mark "0" if present, "3" if missing)				
Does your child eat fried foods?				
Section C	**0**	**1**	**2**	**3**
Is your child's mental speed slow?				
Does your child have difficulty with learning or memory?				
Does your child have difficulty with balance and coordination?				
Section D	**0**	**1**	**2**	**3**
Does your child have stress?				
Does your child have enough sleep and rest?				
Does your child not have regular exercise?				
Does your child feel overly worried and scared?				
Section E	**0**	**1**	**2**	**3**
Does your child have temper tantrums?				
Does your child exhibit wild behavior?				
Does your child frequently yell or scream for unnecessary reasons?				
Does your child have an inability to nap or sleep when physically exhausted?				
Is your child overly talkative?				
Does your child fidget and squirm when seated?				
Does your child run and climb excessively when it is inappropriate?				
Does your child have difficulty playing quietly or engaging in leisure activities?				

Section F	0	1	2	3
Does your child get excited easily?				
Does your child have anxiousness and panic for minor reasons?				
Does your child find it difficult to relax when she/he is awake?				
Does your child have disorganized attention?				
Section G	**0**	**1**	**2**	**3**
Does your child seem depressed?				
Does your child have mood changes with overcast weather?				
Does your child have symptoms of inner rage?				
Does your child seem uninterested in games/hobbies?				
Does your child have have difficulty falling into deep restful sleep?				
Does your child seem uninterested in friendships?				
Does your child have symptoms of unprovoked anger?				
Does your child seem uninterested in eating?				
Section H	**0**	**1**	**2**	**3**
Does your child have difficulty handling stress?				
Does your child have anger and aggression while being challenged?				
Does your child feel tired even after long sleeps?				
Does your child tend to isolate from others?				
Does your child get distracted easily?				
Does your child have constant need and desire for candy and sugar?				
Does your child have disorganized attention?				
Section I	**0**	**1**	**2**	**3**
Does your child have difficulty with visual memory?				
Does your child have difficulty remembering locations?				
Does your child have fatigue or low endurance for learning activities?				
Does your child have difficulty with attention or low attention span or endurance?				
Does your child have slow or difficult speech?				
Does your child have uncoordinated or slow movement?				

ALLERGIES

Drug or Food	Reaction

DENTAL

Last Dental Visit: _____ Dentist: _____

Any important dental information: _____

_____

HOSPITALIZATIONS, SURGERIES, & TRAUMA HISTORY

Hospitalization / Surgeries / Illness / Trauma	Year

MEDICATIONS

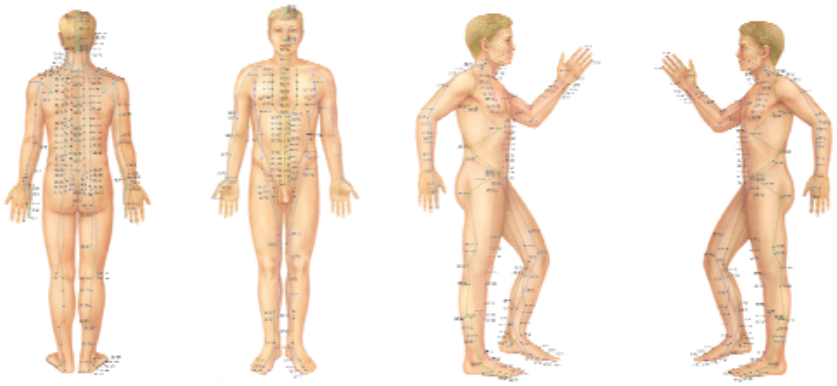
Medication	Reason

VITAMIN & HERBAL SUPPLEMENTS

Supplement	Reason

PAIN PATIENTS

Please indicate on the figures below the areas of the body you experience pain by placing an “X”.



How would you characterize your pain:

___ dull/achy

___ sharp/stabbing

___ tingling

___ electrical

___ burning

___ numbness

DIET

Meal	List the types of foods your child typically consumes.
Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
What does your child crave?	
Any food intolerances?	
Does he/she eat three meals per day?	

HABITS

What are your child's main interests & hobbies? _____

Does your child get 60 minutes of physical activity per day? ___Y ___ N Explain: _____

Does your child smoke or chew tobacco? ___ Y ___ N If not currently, have they ever? _____

Does your child use recreational drugs? ___ Y ___ N Explain: _____

Has your child been treated for drug dependence? ___ Y ___ N Explain: _____

FAMILY HISTORY

Please mark if your child or any of your family have experienced:

Illness	Self	Father	Mother	Sister	Brother	Other
Anemia						
Arthritis						
Asthma						
Cancer						
Diabetes						
Epilepsy						
Gallbladder Disease						
Glaucoma						
Goiter						
Hay Fever, Hives						
Heart Disease						
Heart Murmur						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Mental Illness						
Stroke						
Tuberculosis						
Ulcer						
Other						

CONSENT & RECORD OF DISCLOSURES

By signing below you acknowledge that you have read, fully understand and agree to all the information in the Introductory Patient Information packet. My sole purpose and intent in seeking the services of Lakeside Holistic Health, PLLC is to obtain help for my child's health. My signature is entirely voluntary and based upon informed choice. I also acknowledge this as a Notice of Information Practices. As a patient guardian you have the right to see, copy and supplement your medical records. Medical records obtained in this office may only be used for health care related functions and Lakeside Holistic Health, PLLC will not share or release records without patient guardian authorization.

I acknowledge that I am 18 years of age or older.

I understand that Lakeside Holistic Health, PLLC does not provide after hours services, and that in case of emergency I should contact the appropriate licensed health care provider.

I am aware of Dr. Langenderfer's professional training as a Naturopathic Physician and Licensed Acupuncturist and have been informed to my satisfaction.

I am aware of Dr. Bailey's professional training as a Chiropractic Physician and a Certified Acupuncturist and have been informed to my satisfaction.

I understand that I am financially responsible for all products and services that my child receives from Lakeside Holistic Health, PLLC.

I understand that payment is due at the time of service for treatments and services not covered by my insurance plan.

Consent to Bill Third-Party Payer (Commercial Insurance)
I understand that some third party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Lakeside Holistic Health, PLLC to release all medical information necessary to secure payment of benefits from my insurance carrier.

FINANCIAL CONSENT & AGREEMENT

For your convenience we are Preferred Providers with most commercial insurance carriers. We are happy to complete and submit insurance claims when coverage is available for you. If we are not contracted with your insurance carrier we may be able to submit a courtesy claim on your behalf.

We do not accept Medicare, Medicaid, United Healthcare, or any Medicare or Medicaid supplemental insurance.
We hereby notify you that Lakeside Holistic Health, PLLC and all our Providers have opted out of Medicare and Medicaid. When a physician or practitioner opts out of Medicare and Medicaid, no services provided by that provider are covered by Medicare and no Medicare/Medicaid payment can be made to that provider directly or on a capitated basis. Additionally, no payment may be made to a beneficiary for items or services provided directly by a provider who has opted out of the program(s). Under the statute, the provider cannot choose to opt out of Medicare for some Medicare/Medicaid beneficiaries but not others; or for some services but not others.

By signing this agreement you;

1. Agree not to submit a claim for payment under Medicare/Medicaid, even if such items and services would otherwise by covered by Medicare/Medicaid;
2. Agrees to be responsible for payment of such items and services;
3. Acknowledges that no payment or reimbursement will be provided by Medicare/Medicaid for such items and services;
4. Acknowledges that the provider is not limited in the amount that he or she may charge the beneficiary for the items and services furnished;
5. Acknowledges that quoted benefits from my insurance plan is not a guarantee of coverage and I am responsible for all charges.
6. Acknowledges that it is my responsibility to know my child's insurance benefit information.

Patient Guardian Printed Name		Date	
Patient Guardian Signature			