

NORTHEAST CENTER 
FOR HOLISTIC MEDICINE LLC

Date _____

PEDIATRIC PATIENT PROFILE

A note to parents: Please complete this *three-sided* questionnaire as thoroughly as possible. This is a confidential record of your child's medical information and will not be released, except under the guidelines of the Notices of Privacy Practices.

Patient's Name: _____
Nickname: _____ Date of Birth: ___/___/___ Age: _____ Gender: M F
Address: _____ City: _____ State: _____ Zip: _____
Mother's name: _____ Phone: _____
Father's name: _____ Phone: _____
Email: _____ I would like to receive quarterly E-newsletters []

Please circle the phone number(s) at which detailed messages about your child's medical care may be left at.

Other current health care providers: _____

How did you hear about the Northeast Center for Holistic Medicine? _____

Reason for visit: _____

Please continue on the following pages with your child's health history and information.

PRESENT HEALTH CONCERNS

What goals do you have for your visit at the Northeast Center for Holistic Medicine today? _____

Symptoms:

Now	Past		Now	Past		Now	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>	Gas, colic	<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Body/ breath odor	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Runny/stuffy nose
<input type="checkbox"/>	<input type="checkbox"/>	Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to light
<input type="checkbox"/>	<input type="checkbox"/>	Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Stomach aches
<input type="checkbox"/>	<input type="checkbox"/>	Cries easily	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fears
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting spells
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/bone pain	Other: _____		

Medical History

Medications:

	Now	Past
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Decongestant	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>

Other Medications and Supplements:

Do your child have any allergies (medications, foods, etc) that are severe/ life threatening: **YES NO**

If yes, please describe: _____

Immunizations:

<input type="checkbox"/> Polio	<input type="checkbox"/> MMR	<input type="checkbox"/> HIB	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> DPT	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Other: _____

Childhood Illnesses (Please check if your child has had the following illnesses):

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Tonsillitis/ Strep Throat		<input type="checkbox"/> Ear Infections	
# of times _____		# of times _____	

Has your child had any of the following tests?

	When?	Where?	Results
Electroencephalogram (EEG)	_____	_____	_____
Psychological evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech/Language	_____	_____	_____
Vision	_____	_____	_____

Past injuries/surgeries/hospitalizations: _____

NORTHEAST CENTER 
FOR HOLISTIC MEDICINE LLC

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www.northeast-holistic.com

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use or disclosure of my identifiable health information by the Northeast Center for Holistic Medicine, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at Northeast Center for Holistic Medicine, LLC may be conditioned upon my consent as by my signature on this document.

Practitioner means a Naturopathic Doctor, Acupuncturist, Medical Doctor, Chiropractic Doctor, Osteopathic Doctor, Massage Therapist or other healthcare worker employed by or under contract with the Northeast Center for Holistic Medicine, LLC.

Patient means any person seeking the health care advice and/or treatment of a practitioner at the Northeast Center for Holistic Medicine, LLC through consultation by phone or in person.

My identifiable health information means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This *identifiable health information* relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Northeast Center for Holistic Medicine, LLC is not required to agree to the restrictions that I may request. However, if the Northeast Center for Holistic Medicine, LLC agrees to a restriction that I request, the restriction is binding upon the Northeast Center for Holistic Medicine, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that the Northeast Center for Holistic Medicine, LLC has taken action in reliance of this consent.

I understand that I have the right to review the Northeast Center for Holistic Medicine, LLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Northeast Center for Holistic Medicine, LLC.

Northeast Center for Holistic Medicine, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care: Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, and American Express.

We are currently unable to bill insurance in the states of New Hampshire and Massachusetts.

- Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- The Northeast Center for Holistic Medicine, LLC does not guarantee reimbursement by the patient's insurance company.
- I understand that it is not the responsibility of the Northeast Center for Holistic Medicine, LLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

Cancellation Policy:

The Northeast Center for Holistic Medicine, LLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

Signature of Patient or Authorized Representative

Date

Printed name and relationship to patient