



6860 Brockton Ave., Suite 6 • Riverside, CA 92506 • PH: (951) 202-2340 • E: info@calnc.com

Pediatric Intake Form

Today's date: _____

Personal Information

| | | | |
|-----------------------------------|-------------------------------|-----------------------|---|
| Child's first name | Child's last name | Child's date of birth | Child's gender <input type="checkbox"/> M <input type="checkbox"/> F |
| Parent's/Guardian's first name | Parent's/Guardian's last name | | |
| Home address (number and street). | | | Apt. no. |
| City, state, and ZIP code. | | | |
| Home phone number | Cell phone number | Email address | |

How were you referred?

- Internet search
- Facebook
- Word of Mouth _____
- Other _____

Contact Preferences

- I'd like to receive appointment reminders via email
- I'd like to receive your free wellness newsletter via email

Emergency Contact

| | | |
|-----------------------------------|--------------|--------------|
| Emergency contact name | Relationship | Phone number |
| Home address (number and street). | | Apt. no. |
| City, state, and ZIP code. | | |

Please list the main reason(s) for your child's visit today in order of importance.

Health History

Last blood work/testing (year): _____ Abnormal labs in the past: Yes No
 Last physical exam (year): _____ Abnormal exam(s) in the past: Yes No

Please list any known allergies (environmental, drug, food).

If any of the following apply to your child please indicate *dates*:

Hospitalization _____ X-ray _____ CT scan _____
 Surgery _____ MRI _____ Other _____

Please list any pharmaceutical and/or natural medications (including vitamins) that your child is **currently** taking.

| Medication | Dosage | Date began taking | Reason for taking |
|------------|--------|-------------------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Diet

Please list any food sensitivities/intolerances/dietary restrictions? _____

Review of Symptoms

For the following conditions and symptoms, please indicate any that apply to you by checking “C” for current or “P” for past.

- | | | | | | | | | |
|----------------------------|----------------------------|--|----------------------------|----------------------------|--|----------------------------|----------------------------|---|
| <input type="checkbox"/> C | <input type="checkbox"/> P | <input type="checkbox"/> Skin rash | <input type="checkbox"/> C | <input type="checkbox"/> P | <input type="checkbox"/> Fatigue | <input type="checkbox"/> C | <input type="checkbox"/> P | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Eczema/Hives/Rashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Measles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Numbness/tingling/paralysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yeast Infections/Thrush | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain or ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Rubella | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Colic/Gas/Cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Mumps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Memory loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Excessive thirst/hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Frequent antibiotic use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Head Injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Frequent colds or flu | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Dental problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Physical/Sexual Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cold sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Mood swings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Ear infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Impaired hearing/vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Problems with urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sinus problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Asthma | | | |

Family History

If your child or anyone in your child’s family has had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

- | | |
|---------------------------|---------------------------------|
| Cancer _____ | Asthma, hay fever, rashes _____ |
| Heart disease _____ | ADD/ADHD _____ |
| High blood pressure _____ | Depression _____ |
| Kidney disease _____ | Autoimmune disease _____ |
| Diabetes _____ | Other _____ |

Immunization History

Please indicate those your child has received and any reactions:

- | | |
|--|--|
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis (DTaP) _____ | <input type="checkbox"/> Hepatitis A (Hep A) _____ |
| <input type="checkbox"/> Haemophilus Influenza B (Hib) _____ | <input type="checkbox"/> Measles, Mumps, Rubella (MMR) _____ |
| <input type="checkbox"/> Inactivated Polio (IPV) _____ | <input type="checkbox"/> Pneumococcal (PCV, PPV) _____ |
| <input type="checkbox"/> Meningococcal _____ | <input type="checkbox"/> Hepatitis B (Hep B) _____ |
| <input type="checkbox"/> Human Papillomavirus (HPV) _____ | <input type="checkbox"/> Varicella (Chicken Pox) _____ |
| <input type="checkbox"/> Flu _____ | <input type="checkbox"/> Rotavirus _____ |

Prenatal History

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, bleeding, toxemia, hospitalizations, medications taken)? Please explain _____

How was the labor and delivery? Were there any interventions (i.e., forceps, vacuum, C-section)? _____

Was your child born: Pre-term Post-Term

Neonatal/Infant History

Child's weight at birth _____ Child's length at birth _____

How were your child's APGAR scores at birth, if known? _____

Was your child breast fed? Yes No

If yes, for how long? _____

If no, what formula was your child given? _____

Was your child healthy during the neonatal period? Yes No

If no, please explain _____

At what age was solid food introduced? _____

Social History

Does your child attend daycare or school? Yes No

If Yes, what grade/level are they in? _____

How is your child's social and academic performance (both in school and at home)? _____

Is your child involved in any extra-curricular activities, sports, hobbies? Yes No

Please explain: _____

What does your child enjoy doing in their spare time? _____

Does your child get exercise? Yes No

How often/What type? _____

How much sleep does your child get, on average? _____

Toxic exposure:

Lead

Mercury

Solvents

Sensitive to chemicals/perfumes

Other _____

Major life changes in the last year _____



Informed Consent and Request for Naturopathic Treatment

I understand that naturopathic evaluation and treatment may include, but is not limited to:

- Physical exam (general and female)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (use of foods, diet plans, nutritional supplements, and intravenous/intramuscular injections)
- Herbs/natural medicines (prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams or other forms.
- Homeopathic remedies (often highly diluted quantities of natural occurring substances)
- Over the counter and prescription medications

I understand, and I am informed that in the practice of Naturopathic Medicine there are some risks and benefits with evaluation and treatment including, but not limited to the following:

- Potential risks: allergic reaction to prescribed herbs, supplements, prescription medications; and aggravation of pre-existing symptoms.
- Potential benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
- Notice to pregnant women: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explains therapies and procedures to my satisfaction. I further acknowledge that no guarantees or services have been made to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____



Financial Policy

Appointments

New patients booking your first appointment must reserve your appointment time with a valid credit card number. [**Don't have a credit card?** That's okay. Call our office to book a same-day appointment (no credit card required-subject to availability). Or, stop by and book in-person by prepaying for your appointment.] Your card will not be charged before your appointment time. On the day of your visit, you may pay with cash, debit or credit card (we do not accept checks). We will keep your credit card number on file for return visits subject to our cancellation policy below.

Cancellations

If you need to change or cancel your appointment, you must call or email our office at least **24 hours** in advance of your scheduled appointment time (if the office is closed leave a message or email us). You may also cancel your appointment through our online booking site (the link is on our website at calnc.com). This applies to New Patient Visits, Return Patient Visits and all other therapies including IV therapy.

More than 24-hour cancellation notice = No charge

No cancellation notice/less than 24-hour notice = Your credit card on file will be charged the full visit price including for IV Vitamin Drips. Any pre-paid service (i.e., IV packages) will be reduced by 1 for each missed appointment for that service.

Payment Policy

Payment for services is due at the time services are rendered.

Insurance Reimbursement Policy

Naturopathic doctors' services may be covered by some PPO plans as out-of-network providers. ***We do not bill insurance companies directly.*** For submission of a claim for reimbursement on your own, a superbill providing a summary of the services rendered, diagnoses and charges applied, will be provided to you upon request.

By signing below, I have read and agree to the above policies.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____



Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPAA)

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Parent's (Guardian's) Name: _____

Parent's (Guardian's) Signature: _____ Date: _____



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Consent to receive “Text message” reminders for appointments from Full Slate appointment-booking site

I _____ agree to receive text message appointment reminders to my cell phone number _____ from California Naturopathic Clinic (CaINC). I understand I will receive no more than one (1) to two (2) messages per appointment. I understand that carrier message and data rates may apply to these messages. I understand that my consent to receive text appointment reminders is not a condition of purchasing services or products from CaINC or Dr. Dzvonic. I may choose to stop receiving text reminders at any time by texting “STOP” to 36070. I can find Full Slate’s complete text message policy at: <http://www.fullslate.com/sms>

Patient’s Name: _____

Patient’s Signature: _____ Date: _____

Parent’s (Guardian’s) Name: _____

Parent’s (Guardian’s) Signature: _____ Date: _____