Helping Adults, Children, & Families, Naturally

Pediatric Health History

Name:____
Birth Date _____________ **Age**___________

Male______ **Female**______
Height_____________ **Weight** ____________

Names of Parents or Legal guardians ____________________

Occupation of Parents or Legal Guardians
____
____

Who may I thank for referring you?_____________________

Please list your child's health concerns in order of importance to you:

1.
2.
3.
4.
5.
6.

Medical History

1. **Primary Doctor(s):**

Name	Phone Number	City & State

2. **Therapists (Speech, Occupational, etc.):**

Name	Phone Number	City & State

3. **Naturopathic Doctors:**

Name	Phone Number	City & State

4. **Specialists/Other:**

Name	Phone Number	City & State

5. **Has your child been diagnosed with any genetic or other condition? If yes, please specify.**

___

___

___

Family History

CONDITION	WHO?
Allergies	
Asthma	
Autism Spectrum Disorder	
Autoimmune Disease	
Cancer (list type)	
Developmental Delay	
Diabetes	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Mental Emotional Condition	
Neurological Condition	
Osteopenia or Osteoporosis	
Seizures	
Stroke	
Thyroid Condition	
OTHER	
OTHER	

Dietary/Nutritional History

Breast fed? If yes, how long?	
Brand of formula	
Age formula began	
Age of first foods	
What were first foods?	
Whole milk? If so, what age?	
Known allergies or sensitivities to foods (list foods and reactions)	
Food cravings	
A typical breakfast consists of:	
A typical lunch consists of:	
A typical dinner consists of:	

Early Childhood Illnesses

Number of earaches in first two years	
Number of other infections in first two years	
Number of prescriptions of antibiotics in first two years	
Age of first antibiotic	
Age of first illness	
If there are/were developmental issues, what age did they first appear?	

Developmental History

Please indicate age in months for the following milestones:

Sitting up	
Crawling	
Pulled to stand	
Potty trained	
Dry at night	
Walked alone	
Running	
Pedaling	
First words	
Spoke clearly	
Put on clothing	
Lost language? If so, at what age?	
Lost eye contact? If so, at what age?	

Medications and Supplements

Medication/Suppl-ement	Dates Used	Any response or reaction? If so, what?

Laboratory Testing History

Name of Test	Date of Test	Results

Chemical & Environmental Exposures

1. **Do you live near an industrial area or factory?**
   ____
2. **Has your child ever swallowed household chemicals?**
   ____
   ____
3. **Has your child ever experienced a reaction to a vaccination?**
   ____
   ____
4. **Did you (parent/caregiver) ever work in a place where there was high exposure to pollution or toxins? (industrial plant, hair salon, vehicle repair shop, etc.)**
   ____
   ____
5. **Other known toxic exposures**
   ____
   ____
   ____

Medical History

Surgeries	Date	Results

Injuries	Date	Results

Illnesses	Date(s)	Complications
Ear Infection		
Sinus Infection		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Flu		
High Fevers (>102 F)		
Other		
Other		

Immunizations

Name	Date	Age	Bowel	Swellin g	Crying	Seizur e	Irritabl e	Fever	Other
DPT1									
DPT2									
DPT3									
DPT4									
DPT5									
Hib1									
Hib2									
Hib3									
Hib4									
Polio1									
Polio2									
Polio3									
Polio4									
Polio5									
MMR1									
MMR2									
HepB1									
HepB2									
HepB3									
Chicken-pox									
Flu									
Other									

Diets

Now	Past	Diet Name	Response
		Gluten Free	
		Casein Free	
		Yeast Free	
		High Protein/Low Carb	
		Feingold	
		IgG Food Allergy	
		Specific Carbohydrate Diet	
		NAET	
		Blood Type	
		VEGA	

Therapies

Now	Past	Type	Results
		ABA	
		Acupuncture	
		Chiropractic Medicine	
		Counseling	
		Craniosacral Therapy	
		Hippotherapy	
		Homeopathy	
		IV Therapy	
		Listening Program	
		Naturopathic Medicine	
		Occupational Therapy	
		Physical Therapy	
		RDI	
		Speech Therapy	
		Other	

Signs and Symptoms

Please check those that apply to your child and write any observations

Now	Past	Symptom	Comment
		Likes to be cuddled	
		Physically coordinated	
		Happy	
		Sensitive/ affectionate	
		Wants to be liked	
		Responsible	
		Draws pictures	
		Answers questions	
		Follows instructions	
		Pronounces words	
		Unusual memory	
		Good with math	
		Good with computers	
		Good throwing and catching	
		Good climbing	
		Desire to do things	
		SLEEP	
		Sleeps in own bed	
		Awakens screaming	
		Difficulty falling asleep	
		Daytime sleepiness	
		Nightmares	
		Sleepwalking	
		Sleeps more or less than normally	

		PHYSICAL	
		Overweight	
		Underweight	
		Dark circles under eyes	
		Enlarged neck lymph nodes	
		Night sweats	
		Abnormal fatigue	
		Failure to thrive	
		Unusual Body Odor	
		SKIN	
		Pale	
		Fungus – fingernails	
		Fungus – toenails	
		Dandruff	
		Athletes Foot	
		Diaper Rash	
		Eczema	
		Acne	
		Flushing	
		Bites nails	
		Brittle nails	
		Easy bruising	
		White spots or lines in nails	
		Oily Skin	
		Dry Skin	
		Itchy Skin	
		DIGESTIVE	
		Bad breath	
		Drooling	
		Canker sores	
		Bleeding gums	

		Teeth Grinding	
		Cavities	
		Amalgam Fillings	
		Thrush	
		Burping	
		Nausea	
		Flatulence (Gas)	
		Vomiting	
		Abdominal Bloating	
		Abdominal Pain	
		Colic	
		Parasites	
		Constipation	
		Diarrhea	
		Red Ring Around Anus	
		Stool Color Dark	
		Stool Color Pale	
		Stool With Blood	
		Undigested Food in Stool	
		EATING	
		Poor Appetite	
		Increased Appetite	
		Excessive Thirst	
		Thirst-less	
		Food Cravings (List)	
		Foods won't eat	
		Pica (eating inedible foods)	

		Behavior Worse With Food	
		BEHAVIOR	
		Aloof, distant	
		Bites or chews fingers	
		Bites hands	
		Constant movement	
		Curious, Gets Into Things	
		Destructive	
		Head Banging or other self-harm behaviors	
		Hyperactive	
		Poor Focus/ Attention	
		Toe Walking	
		Uninterested In Pet	
		Mean To Pets	
		Teases Others	
		Unpredictable	
		Poor Eye Contact	
		Flaps Hands	
		Licking	
		Likes Spinning Objects	
		Rhythmic Rocking	
		Sits and Stares	
		Lacks Initiative	
		Stimming (repetitive actions or movements)	
		Aggressiveness (hurts others)	

		Fears/Anxieties (please list)	
		SENSORY	
		Unaware of Danger	
		Insensitive or Oversensitive to Pain	
		Sensitive to Sounds	
		Hearing Acute	
		Hearing Loss	
		Likes Head Pressed or Rubbed	
		Sensitive to Odors	
		Sniffs Things	
		Excessive Blinking	
		No Blinking at Bright Light	
		Poor Vision	
		Collects Things	
		Fixated on One Thing	
		Lines Objects Up Precisely	
		Repeats Phrases, Sentences	
		Repetitive Play	
		Upset if Things Change	
		GENERAL	
		Seizures	
		Stiffens Body When Held	
		Unusual sound or Cry	
		Heart Murmur	

		Cold Hands and Feet	
		Cold Intolerance	
		Moaning	
		COMMUNICATION	
		Poor Language	
		Points to Objects but Can't Name	
		Talks to Self	
		Inconsolable Crying	
		Mood Swings	
		MUSCULAR	
		Muscle Cramps	
		Muscle Pain	
		Clenching	
		Twitching	
		Poor Muscle Tone (Hypotonia)	
		REPRODUCTIVE	
		Girls: Age First Menses	
		Boys: Undescended Testicle	
		Early Breast Development	
		Early Onset Pubic Hair	
		URINARY	
		Bed-wetting After Age 4	
		Odd Urinary Odor	
		Urinary Tract Infections	
		Urinary Urgency	

		OTHER (List)	
		Dyslexia	
		Learning Disability	
		OTHER	
		OTHER	
		OTHER	

Prenatal History

- **Maternal age at delivery __________ years**
- **Difficulty getting pregnant? Fertility Treatment?**
  ____
- **Fertility drugs?**
  ____
- **Medications During Pregnancy?**
  ____
- **Rhogam or Flu shot during pregnancy?**
  ____
- **Recreational Drugs or Alcohol During Pregnancy?**
  ____
- **Complications during pregnancy?**
  ____
- **Mode of delivery: C-section/vaginal**
  ____
  ____
- **Forceps or vacuum used?**
  ____
  ____
- **Medications during labor and delivery**____
  ____

- **Hospital/Birthing Center/Home birth**

  ____

- **Full term, premature, over due, or breech delivery?**

  ____

- **Medications given to baby at or after birth**

  ____

Use the space below to provide me with any additional information

MISCELLANEOUS

1. **Do you (child and/or parents and caregivers) have a spiritual or religious practice? If so, what does it consist of? (church, temple, meditation, yoga, etc)**____

   ____

THANK YOU!

Helping Adults, Children, & Families, Naturally

CONFIDENTIAL CONTACT INFORMATION

Date: _____________ **Full Legal Name:** ______________________________________

Date of Birth: _____________ **Preferred Name:** ________________________________

E-Mail Address:

____

Address

____

City :____________________ **State:** ______________________ **Zip:** _______________

Phone: (H)______________________ **(C)** _____________________ **(W)**_________________

Age: ____________ **Gender: F__ M___**

Emergency Contact Name: ____

Relationship: ____

Phone: ____

COMMUNICATION

What is the best way to communicate with you between office visits? Email/ H Ph/ Cell Ph/ Wk Ph

Is there any place you do NOT want me to leave a message? _____________________________

May I discuss your private medical information with you via email? Yes/ No

May I send you educational/promotional materials such as newsletters via email? Yes/ No

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature :______________________________________**Date:** _____________________

Helping Adults, Children, & Families, Naturally

INFORMED CONSENT FOR PURPOSES OF HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Dr. Julie Glass and Health From The Heart originate and maintain health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source of information for applying my diagnosis to my bill
4. A means by which a third-party payer can verify that services billed were actually provided
5. A tool to conduct routine health-care operations such as quality assessment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that I may revoke this consent in writing at any time, except to the extent that Dr. Glass has taken action relying on this consent.

Patient (or Legal Guardian) Name:

Signature:

Relationship to patient:

Date:

Helping Adults, Children, & Families, Naturally

Thank you for choosing Health From The Heart, LLC to assist you with your healthcare needs. I am dedicated to helping you improve your health. Please fill out all of the papers in this package and bring them with you to your first appointment. Read this form carefully, and sign and date at the end.

- Our first appointment is the longest, since during this time I listen carefully to your health concerns, review your medical history, and we begin the process of creating an treatment plan individualized to your needs. Please set aside 1 ½ hours for this visit. If you are bringing your child in to be treated and he/she is not able to tolerate the full appointment length we will divide the session into as many pieces as is necessary to fulfill his/her needs. Allow 45 minutes for follow up appointments.
- Full payment is required at the time of service. I accept cash, check, visa, and master-card.
- I respect your time and make every effort to schedule appropriately. If you need to reschedule your appointment, please do so at least 48 hours in advance. If you do not reschedule or cancel your appointment with sufficient notice, you will be charged for the entire appointment and this fee is not billable to insurance.
- If you are faced with an emergency after hours, call my main number (503 522-6356), and you will receive the contact number for the physician on-call.
- If you would like to make a phone appointment, either between visits or in place of a face-to-face follow up visit, that is possible (unless I feel as if there is a medical reason that I need to see you in person). The price for any phone conversation that lasts over 10 minutes is $50 per 15 minutes, and is not billable to insurance.
- It is your responsibility to know your insurance benefits (see included form). If your insurance covers my services, I will bill them, and you will be responsible for your copay and any non-covered services at the time of your visit. Since I am a single practitioner, and strive to provide you with the best medical care at the most affordable price, I ask that you take responsibility for resolving any discrepancies with insurance that might arise. You are responsible for paying

Health From The Heart, LLC the full amount while any insurance negotiation takes place. If insurance reimburses me for something that you have paid, I will mail you a check.

- If I prescribe supplements for you, assume you are to continue taking them (until I recommend otherwise). You can call me to pick up supplements in-between office visits, pick them up at your office visits, or order them from my on-line vendor. Please let me know if you are interested in ordering your supplements on-line.

- To refill prescription medications, call your pharmacy at least 7 days in advance.

Your referrals are the life of my business, and I **thank you** for all of them! I also welcome and appreciate **written testimonials**.

Again, thank you for your trust. By signing below you acknowledge that you have read the above office policies and agree to abide by them.

Signed___________________________________ Self/Parent/Legal Guardian

Date_______________________

Helping Adults, Children, & Families, Naturally

INSURANCE BENEFITS VERIFICATION

(Please allow 1 hour for this form, and bring it completed to your first appointment)

If you would like me to bill your primary insurance carrier, please fill out this form. Bring it completed, as well as your insurance card, to your first appointment. I do not bill secondary insurance.

PATIENT INFORMATION

Name ____

Address ____

Phone ____

Company Providing Insurance____

INSURED INFORMATION (if different than above)

Name____

Address ____

Phone _____________________________ Company ________________________

Date of Birth ___________________ Relationship to Patient _______________

INSURANCE COMPANY INFORMATION

Name ____

Phone ____

Billing Address ____

ID# ___________________________________ Group # _____________________

It is your responsibility to be aware of your benefits, including coverage, co-pay, deductible, and maximums. Please call the number listed on the back of your insurance card, and fill out the form below.

1. Name of Representative I am speaking with ___________Date ___________
2. Beginning Date of Coverage _______________ Ending Date __________
3. Does my insurance cover Naturopathic Doctors? Yes/ No
4. Is Dr. Julie Glass, ND a covered provider under my plan? Yes/ No
5. Do I need a referral from my primary care physician to see Dr. Julie Glass, ND? Yes/ No
6. What is my co-pay or % covered for Dr. Glass for:
    1. Office Visits _____________________________
    2. Lab Work _______________________________
    3. Diagnostic Imaging _______________________
7. What is my yearly maximum for naturopathic office visits? ________________
8. What is my yearly maximum for naturopathic-ordered lab work/diagnostic imaging? _________________
9. Do I have an annual deductible? Yes/ No Amt. of deductible met so far _____
10. Is my deductible based on calendar year? Other? _____________________
11. Is Providence a preferred lab? Yes/ No Portland Adventist Hospital Lab? Y/N
12. Other preferred labs? ____

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Dr. Julie Glass/Health From The Heart. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Dr. Julie Glass/ Health From The Heart. This authorization will be considered valid unless revoked by me in writing.

Signature _________________________________ **Date** ________________