SANTA CRUZ NATUROPATHIC MEDICAL CENTER
BIOGRAPHICAL INFORMATION FORM - PEDIATRIC

Santa Cruz Naturopathic Medical Center

Hello and welcome to the Santa Cruz Naturopathic Medical Center!
You can read more about us and our Center at **www.scnmc.com**.

Attached are forms to complete before your child's appointment. Please bring these completed forms with you at the time of your appointment, and also bring any medications, herbs, and/or supplements your child is currently taking. **Please also bring copies of any recent laboratory test results**. If your child has had labs but you do not have the results, we will have you sign a release of record and we can obtain those for you.

The new pediatric exam lasts an hour to an hour and a half, and includes an extensive intake and treatment plan. The cost is $220. **Follow-up appointments are charged according to the time spent with the doctor, and phone appointments are available at the same rates.**

Your child may also receive supplements on the first visit (i.e. vitamins, herbs, homeopathics, etc.) for an additional charge. **The Center does not accept returns or give refunds on any supplements or medications provided.** Payment is due in full at the time of the visit.

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call.

We look forward to seeing you at your appointment and partnering with you in your child's health.

Please be sure to read our Cancellation policy on the following page.

Appointment Date:_____Time:_____

Our clinic is located at 736 Chestnut Street in Santa Cruz, CA 95060. If you need further directions, or if you have any questions, please don't hesitate to call us at 831-477-1377.

Cancellation Policy

SCNMC works diligently to provide suitable and convenient appointment times for all of our patients to assist them in receiving excellent care. Patients are encouraged to schedule their appointments well ahead of time, with the understanding that last minute appointments are very difficult for us to accommodate. We request that patients please try to commit to the appointment times they schedule, and we understand that sometimes things come up. The following is our cancellation policy:

If you need to cancel or reschedule, we require **a 48 hour notice** (2 business days) for a new patient exam. For example, if your appointment is on a Thursday, you would need to cancel by Tuesday morning at the latest. You will be charged a **$150 cancellation fee** for a missed appointment or canceling with less than 48 hour notice.

For all other appointments we require a **24 hour notice** (one business day) for both canceling and rescheduling. The cancellation fee for less than a 24 hours notice is **the cost of the scheduled appointment time.**

Patients who arrive late may or may not be seen depending on the schedule; this is at the discretion of the doctor. Patients who are scheduled to receive an IV will be responsible for the cost of their IV if the appointment is missed.

SCNMC makes reminder calls 3 business days before your new patient intake and 2 days before your follow-up appointment, however, each patient is responsible for keeping their scheduled appointment. Waiting until the reminder call is unadvisable as that call sometimes falls after the cancellation window has closed.

Should you have any questions regarding these policies, please contact us at 831-477-1377.

Insurance

Naturopathic Clinic care is covered under many policies by medical insurance providers. Please call the number on the back of your insurance card and ask if your specific policy covers **Naturopathic** care. If you have insurance coverage for naturopathic care, we will be happy to provide a superbill to you so you can submit for reimbursement. We require payment in full at the time of service. We accept Visa, MasterCard, American Express, check or cash.

Here's how to increase your chances of getting coverage for alternative treatments:

1) Check Your Policy

If you're seeking coverage for complementary and alternative medicine, start by carefully studying your health insurance plan. Since many plans have considerable limits to their coverage, you should also call your insurance company and ask the following questions before you begin treatment:

- Does my plan only cover services determined to be medically necessary?
- Does complementary care need to be pre-authorized or pre-approved?
- Does my plan limit the conditions it will cover?
- Will I need to see a practitioner in your network?
- Is coverage available for care provided by out-of-network practitioners?
- Is there a co-payment?

2) Know Your Visit Limits

Many insurance companies restrict the number of visits that will be covered within a certain period of time. Because alternative therapies often require a series of sessions in order to complete treatment, it's important to be aware of your visit limits prior to pursuing complementary care.

3) Make a Case for Your Coverage

If your insurance company is unwilling to cover the complementary care you're seeking, consider asking your primary-care physician to give you a prescription (including your diagnosis and the suggested frequency of treatment). You can also attempt to convince your insurer that your desired complementary care is more cost-effective than such standard medical treatments as surgery and medication.

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Date: _____

Personal Information:

Name: _____ Age: _____

Date of Birth: _____ Weight: _____ Height: _____ Gender: __ M __ F

Parent/Guardian: _____ Phone (home): _____(work/cell) _____

Address: _____
Street and Number City State Zip

Emergency Contact _____ Phone _____ Relationship _____

E-mail: _____

As patient at SCNMC, you will receive our monthly email newsletter informing you of upcoming specials and events. You may choose not to receive this email newsletter by checking here _____.

Insurance Carrier: _____

How did you hear about our clinic? _____

Present Health Goals:

List in order of importance your primary health goals:

1) _____
2) _____
3) _____
4) _____

Present Health Concerns:

List in order of importance your primary health concerns:

1) _____
2) _____
3) _____
4) _____

Medical History

Your primary physician:

Physician's Name: _____

Address: _____ Phone # _____

Last complete Physical Exam:
Month_____ Year _____ Dr. _____

Last Bloodwork:
Month _____ Year _____ Dr. _____

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For the following please describe event and list date of occurrence:

Surgeries:_____
Major Accidents:_____
Hospitalizations:_____

For the following please list name/brand of medication/supplement and dosage:

Medications:

_____

Vitamins/Minerals:

_____

Herbs or Homeopathics:

_____

Prenatal History:
During the pregnancy did any of the following occur:

- ❑ emotional/physical stress or trauma
- ❑ hypertension
- ❑ pre-eclampsia
- ❑ nausea/vomiting
- ❑ gestational diabetes
- ❑ infections
- ❑ bleeding
- ❑ tobacco use
- ❑ alcohol use
- ❑ recreational drug use
- ❑ anemia

Age of parents at conception: Mother _____ Father _____

Natal History:

Length of pregnancy: _____
At Birth: Weight _____ Length _____ Apgar score _____

Type of Delivery: vaginal ❑ cesarean ❑

Labor: spontaneous ❑ induced ❑

Interventions: epidural ❑ episiotomy ❑ forceps ❑

Duration of hospital stay/homebirth:

_____

Neonatal History (0 - 2 months):
Did your child experience any of the following complications after birth:

- ❑ hypoxia
- ❑ feeding complications
- ❑ meconium
- ❑ rashes
- ❑ colic
- ❑ jaundice
- ❑ voiding/eliminating difficulties
- ❑ fevers
- ❑ infection

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Childhood Health History:

Vaccinations:

- ❑ Diphtheria - tetanus - pertussis (DTP)
- ❑ Hemophilus B
- ❑ Polio
- ❑ Measles
- ❑ Rubella
- ❑ Mumps
- ❑ Tetanus

Please list any adverse reactions to Vaccinations: _____

Infections/Allergies:

- ❑ colds/flu - # in last year
- ❑ ear infections - # in last year
- ❑ rashes
- ❑ hives

Digestion:

- ❑ nausea/vomiting
- ❑ diarrhea
- ❑ stomachaches

Genitourinary:

- ❑ bedwetting
- ❑ delayed potty training

Sleep:

# of hours during night _____Time of falling asleep _____ Time of waking _____

Pattern in 1st year:
Napping? ❑ Yes ❑ No How often?

- ❑ nightmares
- ❑ sleepwalking

Musculoskeletal:

- ❑ trauma - broken bones, etc
- ❑ growing pains
- ❑ growth spurts with joint pain
- ❑ easy bruising
- ❑ slow healing wounds

Neurological:

- ❑ convulsions
- ❑ concussions
- ❑ hearing problems
- ❑ vision problems
- ❑ seizures
- ❑ hyperactivity

Social History:
Is your child in school? ❑ Yes ❑ No Grade _____
Extracurricular activities
_____

Please outline any concerns - e.g. school performance, relationship to authority, stress
_____

Does the child have a spiritual practice?_____
Does the child have a support structure?_____
Does the child have a social network?_____
Does the child have any hobbies?_____
Does the child have a history of abuse? (physical, mental, emotional, sexual)?_____

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Allergies:
Drugs_____
Food _____
Environmental (grasses, pollens, animals, chemicals, etc.)
_____

Exercise:
Does the child have a regular exercise program? If yes, please describe type of exercise and frequency
_____

Childhood Milestones:
Please note when your child performed the following:

_____ rolling over	_____ standing
_____ sitting	_____ walking
_____ crawling	_____ teething
_____ talking	_____ puberty

Diet:
❑ breastfed How long? _____
❑ formula fed Type? _____

Food introduction - type of food and when:
_____

Any difficulties with food introduction:
_____

Current eating habits - picky, likes/dislikes:
_____

Special diets - e.g. vegetarian, wheat free, etc.:
_____

Please describe a typical day's meals:

Breakfast _____

Lunch _____

Dinner_____

Snacks_____

Liquids_____

How much water does the child drink per day (ounces)? _____

Does the child have daily bowel movements?_____ How many?_____
Does the child have any of the following?
❑Diarrhea Frequency: #days per week/month _____
❑Constipation Frequency: #days per week/month _____
❑Blood in stool Frequency: #days per week/month _____

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Family History:

	Father	Mother	Siblings	Grandparents
Age If Living:	_____	_____	_____	_____
Age when Died:	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N
Auto-Immune Dz:	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N
Cancer Y N	Y N	Y N	Y N	Y N

Is there anything that has not been asked on this form that you would like to share, or any specific questions you would like to ask the doctor?

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Informed Consent Form

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed Naturopathic Doctor.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the Naturopathic Doctor the nature and purpose of Naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including Naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a Naturopathic Doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed)_____

I agree to the terms of the cancellation policy. I agree to provide a 24 hour notice of cancellation for all follow-up appointments or pay the cost of the visit. $150 will be charged for new patient exams if cancellations are made with less than a 48-hour notice.

PATIENT SIGNATURE _____**Date:** _____
(or Patient Representative)
Indicate relationship if signing on behalf of patient _____