



As a baby, did/does your child have any of the following problems?

Jaundice Diarrhea Birth defects Rashes
 Cerebral palsy Blue baby Birth injuries Seizures
 Colic Fever Allergies
 Other _____

Feeding: _____ Breast fed _____ How long? _____ Formula: Milk or Soy

Age Began: _____ Solid foods _____ Sitting _____ Crawling _____ Walking
_____ First words

What were your child's sleep patterns during the first year?

BIRTH HISTORY

Date of Birth _____ Term Full
Time of Birth _____ a.m. _____ p.m. Premature
Weight at birth _____ Late

Gestation according to LNMP: _____ weeks
Sonogram _____ weeks
Gestational Assessment _____ weeks

Place of birth Home Birth Clinic Hospital Other _____

Address of Birthplace _____

STREET/PO Box

CITY, STATE, ZIP

Onset of Labor _____ Date _____ Time _____

Duration of Labor _____

Complications of Pregnancy Yes No

Complications of Labor/Delivery Yes No



Complications of Post Partum Yes No

Medications Given

MOTHER'S HISTORY

Previous pregnancies by natural mother, miscarriages or complications:

Mother's age at child's birth: _____

Mother's health during pregnancy

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cigarettes, alcohol, drugs |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Illness | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems | |
-

SYMPTOMS

Circle the response that applies

Y: condition now

P: condition had in the past

N: condition never had

Hives	Y	P	N	Burning of urine	Y	P	N
Eczema	Y	P	N	Bloody urine	Y	P	N
Acne	Y	P	N	Frequent urination	Y	P	N
Chronic rash	Y	P	N	Heart murmur	Y	P	N
Cries easily	Y	P	N	Vomiting spells	Y	P	N
Bleeding gums	Y	P	N	Night sweats	Y	P	N
Nervous	Y	P	N	High fever	Y	P	N
Nose bleeds	Y	P	N	Stomach aches	Y	P	N
Sleep problems	Y	P	N	Diarrhea	Y	P	N
Nightmares	Y	P	N	Constipation	Y	P	N
Dizzy spells	Y	P	N	No appetite	Y	P	N
Unusual fevers	Y	P	N	Motion/car sick	Y	P	N
Anemia	Y	P	N	Sensitive to light	Y	P	N
Jaundice	Y	P	N	Body/Breath odor	Y	P	N
Hearing loss	Y	P	N	Easy bruising	Y	P	N
Flat feet	Y	P	N	Sore throats	Y	P	N
Gas	Y	P	N	Canker sores	Y	P	N
Wheezing	Y	P	N	Cough	Y	P	N
Joint Pains	Y	P	N	Hair loss	Y	P	N
Frequent headaches	Y	P	N	Frequent colds	Y	P	N
Bleeding tendency	Y	P	N	Excessive fatigue	Y	P	N



Does your child have any other condition not mentioned?

DIET

Please describe your child's typical daily diet:

Does your child have any food intolerances or allergies that you know of?

Yes

No

If yes, please explain:

What were the first solid foods introduced into your child's diet?

Are there any religious or cultural beliefs or practices of which you would like us to be aware?

THANK YOU

I certify that the information that I have provided is correct and accurate to the best of my knowledge.

SIGNATURE Parent/Guardian

DATE



INFORMED CONSENT

The purpose of this form is to present the risks & benefits of the therapies offered at **Origins of Health**.

This must be signed before treatment is rendered.

Please feel free to ask your practitioner about any questions or concerns at any time.

NATUROPATHIC MEDICINE

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause of disease rather than focusing on symptomatic treatment. The doctors in our clinic work with a variety of conditions including issues in womens' health, stress, pain, organ dysfunction, infections, and much more. There may be risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

SUPPLEMENTS, HERBAL FORMULAS AND HOMEOPATHIC REMEDIES

These are formulas that can facilitate healing through nutritional and energetic support. Each of these can be effective for a number of conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some transient effects may be gas, bloating, fatigue, and less commonly allergic reaction, but be sure to consult with your naturopathic physician to discern the cause of the symptoms.

IMAGING, REFERRALS

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management, physical therapy, vestibular testing, psychological evaluation, surgery, other naturopathic therapies, chiropractic, acupuncture, massage, etc.

We will inform you of alternatives to the therapies offered within or external to Origins of Health. Our first concern is your health and well-being.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors and if there is a chance of pregnancy at any time during your care.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Signature (Patient or Guardian if a minor)

Date



INFORMED CONSENT

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT and HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Origins of Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Origins of Health. I understand that diagnosis or treatment of me by my physician at Origins of Health may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Origins of Health is not required to agree to the restrictions that I may request. However, if Origins of Health agrees to a restriction that I request, the restriction is binding on Origins of Health and my physician at Origins of Health.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician at Origins of Health has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected 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 I have a right to review Origins of Health Notice of Privacy Practices prior to signing this document. Origins of Health's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Origins of Health. This Notice of Privacy Practices also describes my rights and Origins of Health's duties with respect to my protected health information.

Origins of Health reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Signature (Patient or Guardian if a minor)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)