Naturopathic Medicine Pediatric Intake Form

Today's Date: __________

Last Name: ______________________________ First Name: __________________________ MI: _________

Parent(s): Mother_______________Father______________ Birthdate: _____/_____/_______ Sex: M / F

Mailing Address: ____ City: _________________________

State: _________ Zip Code: ___________ Home Phone: ____

Emergency Contact: __________________________________Relationship to Patient: _________________

Contact's Phone Number: ________________________ Contact's Email: ____________________________

Referred to Aloe Wellness by: ____

Current Health Care Team:

Patient's Pediatrician: ____ Office Number: ______________

Specialist Physician: _______________________ Specialty: ____________ Office Number: _____________

Specialist Physician: _______________________ Specialty: ____________ Office Number: _____________

Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):

Practitioner Name: ____ Office Number: _____________

Practitioner Name: ____ Office Number: _____________

Please list current health concerns, time of onset, and current treatment:

Condition	*Onset/Duration*	*Treatment (if any)*

Aloe Wellness, LLC
5840 MacArthur Blvd NW, Suite 2 • Washington, DC 20016 • (202) 966-2563 • www.aloewellnessdc.com

PAST MEDICAL HISTORY

Pregnancy:

Duration of pregnancy:_______________

Any complications with pregnancy? ____

Type of birth delivery: cesarean section / vaginal Birth Weight:____ lb. Height ____ in.

Any complications with delivery? ____

Newborn:

Any significant health concerns as newborn? (eg. anemia, jaundice, respiratory difficulty, infection)

____

To date, please list history of all major illnesses, hospitalizations, surgical procedures including dates.

____

History of head injury or other major injury? ____

Has this child ever been unconscious or had seizures? ____

Immunizations/vaccinations:

____

____

Date of last Physical/Wellness Exam: ___________________ Date of last Blood Tests:___________________

Please list any Life Threatening Allergies: ____

Other Allergies, sensitivities, or intolerances (eg. food, medication, environmental, chemical, etc.):

____

FAMILY HISTORY:

Place appropriate letter(s) in blank if someone in the child's family has/had any of the following.
(F=Father, M=Mother, S=Sibling, G=Grandparent)

___ Alcoholism
___ Allergies/Eczema
___ Asthma
___ Autoimmune Disorders
___ Cancer, specify type(s): ________________________

___ Crohn's Disease
___ Diabetes
___ Drug abuse
___ Epilepsy/Seizures
___ Headaches/Migraines
___ Heart Disease

___ Neurological Disorders
___ Obesity
___ Sexually Transmitted Infections: ______________
___ Thyroid Disorder

Any other condition:____

LIFESTYLE:
Please select the following that apply to this child (write N/A if does not apply)

___ Stays at home ___ Involved in after-school activities (Ex: ___________________)

___ Daycare (___ days/week) ___ Socializes well with other children

___ School (grade level______) ___ Holds attention while working on a task

Describe the child's family situation: (number of siblings, parental involvement in child's life, etc):

____

____

Favorite Activities: ____

Fears and Anxieties: ____

DIET:

Please check any of following: ___Mixed Diet (animal/vegetable) ___Vegetarian ___ Organic

Please list any Food Restrictions (eg. dairy, gluten, soy, etc.): ______________________________

____

I have completed this form to the best of my ability in reference to this child's health history. I have stated all known health conditions for this child and will alert the physician of any new condition as it arises. I agree to take full responsibility for bringing this child to naturopathic care.

Signature: ____ Date: _________________

Relationship to Patient: ____

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name ______________________________ Date ______________

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past week ☐ Past 30 days

Point Scale
- 0 — Never or almost never have the symptoms
- 1 — Occasionally have it; effect is not severe
- 2 — Occasionally have it; effect is severe
- 3 — Frequently have it; effect is not severe
- 4 — Frequently have it; effect is severe

Head
- ______ Headaches
- ______ Faintness
- ______ Dizziness
- ______ Insomnia

Total ______

Eyes
- ______ Watery or itchy eyes
- ______ Swollen, reddened or sticky eyelids
- ______ Bags or dark circles under eyes
- ______ Blurred or tunnel vision (does not include near- or farsightedness)

Total ______

Ears
- ______ Itchy ears
- ______ Earaches, ear infections
- ______ Drainage from ear
- ______ Ringing in ears, hearing loss

Total ______

Nose
- ______ Stuffy nose
- ______ Sinus problems
- ______ Hay fever
- ______ Sneezing attacks
- ______ Excessive mucus formation

Total ______

Mouth/ Throat
- ______ Chronic coughing
- ______ Gagging, frequent need to clear throat
- ______ Sore throat, hoarseness, loss of voice
- ______ Swollen or discolored tongue, gums, or lips
- ______ Canker sores

Total ______

Skin
- ______ Acne
- ______ Hives, rashes, dry skin
- ______ Hair loss
- ______ Flushing, hot flashes
- ______ Excessive sweating

Total ______

Heart
- ______ Irregular or skipped heartbeat
- ______ Rapid or pounding heartbeat
- ______ Chest pain

Total ______

Lungs
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing

Total ______

Digestive Tract
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Constipation
- ______ Bloated feeling
- ______ Belching, passing gas
- ______ Heartburn
- ______ Intestinal/stomach pain

Total ______

Joints/ Muscles
- ______ Pain or aches in joints
- ______ Arthritis
- ______ Stiffness or limitation of movement
- ______ Pain or aches in muscles
- ______ Feeling of weakness or tiredness

Total ______

Weight
- ______ Binge eating/drinking
- ______ Craving certain foods
- ______ Excessive weight
- ______ Compulsive eating
- ______ Water retention
- ______ Underweight

Total ______

Energy/ Activity
- ______ Fatigue, sluggishness
- ______ Apathy, lethargy
- ______ Hyperactivity
- ______ Restlessness

Total ______

Mind
- ______ Poor memory
- ______ Confusion, poor comprehension
- ______ Poor concentration
- ______ Poor physical coordination
- ______ Difficulty in making decisions
- ______ Stuttering or stammering
- ______ Slurred speech
- ______ Learning disabilities

Total ______

Emotions
- ______ Mood swings
- ______ Anxiety, fear, nervousness
- ______ Anger, irritability, aggressiveness
- ______ Depression

Total ______

Other
- ______ Frequent illness
- ______ Frequent or urgent urination
- ______ Genital itch or discharge

Total ______

For Practitioner Use Only:
Urinary pH ________

Grand Total ________

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Lifestyle Medicine Programs by Metagenics

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
☐ Yes (1 pt.) ☐ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
☐ Cimetidine (2 pts.) ☐ Acetaminophen (2 pts.) ☐ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
☐ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
☐ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
☐ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently within the last 6 months have you regularly used tobacco products?
☐ Yes (2 pts.) ☐ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
☐ Yes (1 pt.) ☐ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

10. Do you have a personal history of:
☐ Environmental and/or chemical sensitivities (5 pts.)
☐ Chronic fatigue syndrome (5 pts.)
☐ Multiple chemical sensitivity (5 pts.)
☐ Fibromyalgia (3 pts.)
☐ Parkinson's type symptoms (3 pts.)
☐ Alcohol or chemical dependence (2 pts.)
☐ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
☐ Yes (1 pt.) ☐ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
☐ Yes (1 pt.) ☐ No (0 pt.) ☐ Don't know (0 pt.)

Total __________

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
☐ Yes (1 pt.) ☐ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
☐ Yes (1 pt.) ☐ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
☐ Yes (1 pt.) ☐ No (0 pt.)

Total __________

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total __________ (High >50; moderate 15-49; low <14)
Part 2: XTT Total __________ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total __________ (High ≥1)
Urinary pH __________

Notes:

- Patients with high Symptoms but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

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Please list any vitamins, minerals, herbal supplements, homeopathics, over-the-counter and prescribed medications and creams that you are taking.

NAME: ________________________________ DATE: ____________

SUPPLEMENT	MANUFACTURER	FORM	DOSAGE	FREQUENCY
EXAMPLE: VITAMIN C	PERQUE	powder	1500 mg= ½ tsp	½ tsp 2 times/day

MEDICATION	FORM	DOSAGE	FREQUENCY	DATE STARTED

Describe any history of drug reaction/allergy: ________________________________

____

OTHER COMMENTS:

Aloe Wellness, LLC
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Informed Consent for Consultation and Treatment

I, ____, hereby authorize the practitioners at Aloe Wellness, LLC to perform the following specific procedures and services as necessary to facilitate in the treatment of myself or my minor child:

Physical exam: e.g., general, musculoskeletal, cardiovascular, abdominal, respiratory
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, solid extracts, or suppositories.
Hormone therapies: natural, bio-identical hormone therapies
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plant, animal, and mineral substances to gently stimulate the body's healing responses.
Lifestyle and nutritional counseling and hygiene: diet therapy, recommendations for exercise, sleep, stress reduction, and balancing of work and social activities, mind-body supportive counseling
Acupuncture and Chinese Medicinal Herbs
Holistic Transformational Coaching
Contraception
Physical Medicine: e.g., Colon Hydrotherapy, Craniosacral therapy, Reiki
Venipuncture: blood draw to be submitted for tests ordered

All practitioners at Aloe Wellness are certified or licensed as require by their jurisdiction.

I understand that the doctors at Aloe Wellness are licensed, board-certified naturopathic physicians in the District of Columbia, based upon a four-year graduate training in an accredited university as a naturopathic physician.

The naturopathic physicians will explain to me their assessment, the nature of their recommendations, the expected prognosis without such care, and the anticipated costs, risks, benefits and experience of following various options. I understand that the focus of naturopathic care is to alleviate the underlying conditions that can bring about illness rather than the treatment of symptoms. While I may experience some immediate improvement from the use of naturopathic methods, I understand that the most effective results occur when I make a long-term commitment to rebuild my health. **It is my responsibility as a patient to follow-up with the naturopathic physicians within a recommended time period for evaluation of treatment results or to change treatment protocols as necessary.**

I understand that the practitioners at Aloe Wellness do not offer after hour services or provide any hospital-based services. If I have difficulty with any of the remedies or other aspects of my work with the doctors, I understand I should call during business hours to discuss concerns I may have.

Potential risks: As with any method of care, there may be risks, such as allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes or injury from procedures. I understand that it is my responsibility to alert the practitioner(s) of any adverse effects or reactions.

Notice to Pregnant Women: All female patients must alert the practitioner(s) at Aloe Wellness if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Important Insurance and Payment Notices: Aloe Wellness does not bill insurance companies, but will supply you with all insurance codes necessary to submit your claims for reimbursement at the time of your visit. Our doctors are not preferred providers for any insurance company, but many companies cover our visit fees as "out of network" physicians. Medicare will not reimburse you for services rendered at Aloe Wellness. Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement, even if my insurer determines that services are not medically necessary. I understand that naturopathic visits by phone are more likely denied reimbursement compared to in-office visits. Both Flex Spending Plans and Health Savings Accounts can often be used to cover any visit fees not covered by your insurance. In addition, they will usually cover any laboratory fees not otherwise covered and most nutritional or herbal supplements prescribed.

Cancellation and Rescheduling of Appointments Policy: Our practitioners request 24-hours notice for canceling or rescheduling appointments. For any visits cancelled with less than 24-hours notice, the patient will be charged the full amount of the original visit fee except in the case of family or medical emergency. This charge will be billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

With this knowledge, I voluntarily consent to the above procedures, realizing that the doctors at Aloe Wellness or any personnel have given no guarantees to me by regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that it is not being recommended to me to discontinue any other treatment or care being provided by any other health care professional. I understand that this care not replace the service of my primary care physician. When appropriate, our doctors may communicate with members of my health team regarding my conditions, treatment options, and/or any other health related issues. I agree to follow-up on referrals for medical care when necessary.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

I have read and understand the above statements.

Patient Name ________________________________ Signature ________________________

Legal Guardian Name (if needed) _______________Signature ________________________

Date __________

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Washington, DC 20016

CREDIT CARD AUTHORIZATION FORM

I herby authorize Aloe Wellness, LLC to record and keep on record the following credit card information. Aloe Wellness is fully committed to the safety and security of our patient's private information and agrees to only preserve this information in our encrypted Electronic Medical Records system.

____

Print your name as it appears on card

____ ____________________

Card Holder Signature Date

Aloe Wellness will never use credit card information without prior permission from the cardholder.

FOR OFFICE USE ONLY – DO NOT ENTER PERSONAL INFO BELOW

____ ____________________

Credit Card Number Exp. Date

____

Last Updated