Sarah Silverman, ND
1221 SE Madison St.,
Portland, OR 97214

Silverman - Pediatric Intake

Please fill this form out in entirety prior to your first appointment.

Referred by _____

Primary Contact Details

Caregiver First Name _____

Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Extn _____

Primary Phone ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

Siblings (Name, gender, age) _____

_____

_____

_____

What are the most important health concerns? _____

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Past Medical History

Child's first year

How was the health of your mother (emotional and physical) during pregnancy? _____

Do either of your parents have a chronic illness? If yes, please describe. _____

Any exposure during pregnancy to:
- ☐ Poor diet
- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ None
- ☐ Others _____

Gestation at birth?
- ☐ <37 weeks
- ☐ 38-40 weeks
- ☐ >40 weeks
- ☐ Others _____

Location of birth?
- ☐ Home
- ☐ Hospital
- ☐ Birth Center
- ☐ Others _____

Type of Delivery
- ☐ Spontaneous vaginal birth
- ☐ Scheduled C-section
- ☐ Emergency C-section
- ☐ Epidural/Anesthesia
- ☐ Nitrous/Fentanyl
- ☐ Pitocin
- ☐ Forceps/Vacuum extraction

Was resuscitation needed? ☐ Yes ☐ No

Birth weight _____

Any complications during pregnancy and delivery? If yes, please explain: _____

Breast Fed?
- ☐ No
- ☐ Collostrum at birth only
- ☐ Exclusively for 6 months
- ☐ Combination of breast milk and formula

If yes, how old when weaned? _____

Formula Used? If yes, tell us which formula(s). _____

First Foods introduced : When / Frequency _____

Vaccination History

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Vaccination history:

- ☐ DTaP
- ☐ Pneumococcal
- ☐ Hepatitis A
- ☐ Varicella
- ☐ Meningococcal
- ☐ Hib
- ☐ Hepatitis B
- ☐ Polio
- ☐ MMR
- ☐ None

Vaccination adverse reactions? If yes, please describe.

Other past medical history

Any major traumas, illnesses or accidents (and when)?

Any hospitalizations, broken bones or surgeries?

Developmental History:

- ☐ Sitting by ~6 months
- ☐ Walking by ~1 yr
- ☐ Baby sign language
- ☐ Unknown
- ☐ Crawling by ~9 mo
- ☐ Talking by 12-18 months, sentences around 2
- ☐ Social Skills matched with peers

Baby had challenges with:

- ☐ Food introductions
- ☐ Sleeping
- ☐ Learning to walk
- ☐ Teething
- ☐ Toilet training
- ☐ Learning to talk

Regression of skills noted ☐ Yes ☐ No

Allergies

Medications

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Supplements _____

_____

_____

Any adverse reaction to therapies? ☐ Yes ☐ No

If yes, please describe: _____

Social History

Average daily diet: _____

_____

_____

_____

Child is in: ☐ School ☐ Daycare ☐ Home with parent or caregiver ☐ Others _____

Behavior at home? _____

Behavior at school? _____

Screentime? ☐ <30 minutes/day ☐ 30 min-1 hour/day ☐ > 1 hour/day

Extracurriculars (what and how often?) _____

_____

_____

_____

Energy level (10 is tons of energy) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often/what kind of exercise? _____

Sleep: ☐ 6-8 hours/night ☐ 8-10 hours/night ☐ >10 hours/night ☐ Naps ☐ Awakens rested ☐ Awakens unrefreshed

Any concerns about environmental factors, toxins or other exposures? _____

Family Medical History

Check family members that apply

Allergies/asthma/eczema	☐ Father ☐ Siblings	☐ Mother ☐ Grandparent
Heart disease	☐ Father ☐ Siblings	☐ Mother ☐ Grandparent
Cancer	☐ Father ☐ Siblings	☐ Mother ☐ Grandparent
Diabetes	☐ Father	☐ Mother

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	☐ Siblings	☐ Grandparent
Anxiety/depression	☐ Father ☐ Siblings	☐ Mother ☐ Grandparent
Auto-immune disease	☐ Father ☐ Siblings	☐ Mother ☐ Grandparent

Other family medical history: _____

_____

_____

_____

Review of Systems

HEENT

Headaches	☐ Yes	☐ No
Dizziness/vertigo	☐ Yes	☐ No
Dry eyes, eye pain, lazy eye	☐ Yes	☐ No
Impaired vision	☐ Yes	☐ No
Frequent ear infections	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No
Frequent colds	☐ Yes	☐ No
Hay fever/allergies	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No
Problems with dentition	☐ Yes	☐ No
Child has a dental home	☐ Yes	☐ No
Strep throat	☐ Yes	☐ No
Difficulty with swallowing	☐ Yes	☐ No
Lumps or bumps on neck	☐ Yes	☐ No

Immune/Infections

Frequent infections or illnesses	☐ Yes	☐ No
Chicken pox	☐ Yes	☐ No
Lyme disease	☐ Yes	☐ No
# of rounds of antibiotics in lifetime?	☐ 0	☐ 1

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	☐ >1 ☐ multiple in one year	☐ >5
Ibuprofen or Tylenol use?	☐ Yes ☐ No	

Cardiac/Respiratory

Heart murmur	☐ Yes ☐ No	
Cyanosis	☐ Yes ☐ No	
Shortness of breath	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Inhaler use	☐ Bronchodilator	☐ Steroid
Bronchitis/pneumonia	☐ Yes ☐ No	

Gastrointestinal

Nausea/vomiting	☐ Yes ☐ No	
Change in appetite	☐ Yes ☐ No	
Restricted eating or eating and purging	☐ Yes ☐ No	
Abdominal pain	☐ Yes ☐ No	
Gas/colic	☐ Yes ☐ No	
Bowel Movements	☐ Diarrhea, Constipation, Alternating diarrhea and constipation, Hard, dry or pellet stool, Undigested food in stool, Black stool, Foul smell, Incomplete, Blood in stool	
Frequency of bowel movements	☐ 1x/day ☐ Every other day	☐ 2-3x/day ☐ <3x/week

Heme

Easy bruising/bleeding	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Jaundice	☐ Yes ☐ Infancy	☐ No

Urinary

Issues around potty-training? _____

Concerns around urination? _____

Bed-wetting? ☐ Yes ☐ No

Gyn

Has had onset of menses ☐ Yes ☐ No

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Early puberty	☐ Yes	☐ No
Labial adhesions	☐ Yes	☐ No
Vaginal odor or discharge	☐ Yes	☐ No
Vaginal infections	☐ Yes	☐ No

M/S:

History of broken bones	☐ Yes	☐ No
Joint pain or stiffness	☐ Yes	☐ No
Pain in limbs at night	☐ Yes	☐ No
Weakness or exercise intolerance	☐ Yes	☐ No

Skin

Rashes/Hives	☐ Yes	☐ No
Itchiness	☐ Yes	☐ No
Dry/flaky skin or scalp	☐ Yes	☐ No
Unusual sweats	☐ Yes	☐ No
Acne	☐ Yes	☐ No

Neuro

Loss of balance	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Poor cognition	☐ Yes	☐ No
Speech or language delays	☐ Yes	☐ No
Delays in motor development	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Concussion/traumatic brain injury	☐ Yes	☐ No

Psych

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Easily stressed	☐ Yes	☐ No
Attention or concentration difficulties	☐ Yes	☐ No

Mood swings	☐ Yes	☐ No
Temper Tantrums	☐ Yes	☐ No
History of abuse	☐ Yes	☐ No
Nightmares	☐ Yes	☐ No

Any additional information which you feel is important can be provided here _____

Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to: - Get a copy of your paper or electronic medical record - Correct your paper or electronic medical record - Request confidential communication - Ask us to limit the information we share - Get a list of those with whom we've shared your information - Get a copy of this privacy notice - Choose someone to act for you - File a complaint if you believe your privacy rights have been violated You have some choices in the way that we use and share information as we: - Tell family and friends about your condition - Provide disaster relief - Include you in a hospital directory - Provide mental health care When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your medical record - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. - We may say "no" to your request, but we'll tell you why in writing within 60 days. Request confidential communications - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. - We will say "yes" to all reasonable requests. - Ask us to limit what we use or share - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. Get a list of those with whom we've shared information - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy

of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. - We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated - You can complain if you feel we have violated your rights by contacting us using the information on page 1. - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. - We will not retaliate against you for filing a complaint. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: - Share information with your family, close friends, or others involved in your care - Share information in a disaster relief situation - Include your information in a hospital directory - If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. Our Uses and Disclosures How do we typically use or share your health information? We typically use or share your health information in the following ways. - Treat you We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. - Run our organization We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. - Bill for your services We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. How else can we use or share your health information? - We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. - Help with public health and safety issues - We can share health information about you for certain situations such as: - Preventing disease - Helping with product recalls - Reporting adverse reactions to medications - Reporting suspected abuse, neglect, or domestic violence - Preventing or reducing a serious threat to anyone’s health or safety We can use or share your information for health research. - Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law. - Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations. Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies. - Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you: - For workers' compensation claims - For law enforcement purposes or with a law enforcement official - With health oversight agencies for activities authorized by law - For special government functions such as military, national security, and presidential protective services - Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena. We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

GUARDIAN SIGNATURE: : _____

Date: _____

Consent to Treatment

To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the doctor's office of any changes in my medical status. I consent to services rendered and treatment provided by Dr. Sarah Silverman at Portland Natural Health. I recognize that Dr. Silverman is a licensed Naturopathic Physician. I have the right to refuse any treatment suggested that I am uncomfortable with. I have the right to ask questions to my satisfaction. Dr. Silverman has the right to treat me within the scope of her practice. Dr. Silverman has the right to refuse rendering of treatment or to make referrals to outside physicians if she feels that she can not be of service to my case.

GUARDIAN SIGNATURE: : _____

Date: _____

Financial Policy

• Missed Appointments/Cancellations

If for any reason you are unable to make your appointment, please give us 48 hours notice. For any missed appointments or less than 48 hour notice for cancellation your account will

be charged $120. If you are late for your appointment, your visit will be shortened and you may also be charged for the reserved time on the schedule.

• Insurance

You are required to confirm naturopathic coverage prior to your initial appointment. Once you have verified your insurance, you will be responsible for any co-pays, deductibles, and amounts not covered by the insurance at the time of service.

• Payments

For cash paying patients, a Time of Service discount will be given to you. We accept cash, checks, and credit cards. A sliding scale fee schedule based upon the US poverty guidelines is available for those who do not have naturopathic insurance coverage. Household proof of income is required to qualify for discounted rates. Payment for any specialty labs is due at the time they are ordered. Phone visits or telemedicine visits not covered by insurance are billed at $35/15 minute increment. Dishonored checks will be charged a $25 fee. Any balances due on your account will be billed to you every 30 days. Balances that are 90 days past due may be submitted to collections if there is no communication.

GUARDIAN SIGNATURE: : _____

Date: _____