Cedar Natural Healthcare, LLC
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Dr. Caryn Potenza
Dr. Desiree Stahl

Date: _____

NEW PEDIATRIC PATIENT INTAKE FORM

Child's Name: _____ Age: _____ DOB: _____

Gender: ❑ Male ❑ Female Height: _____ Weight:_____

Parent/Guardian Name(s):_____

Home Phone: _____ Cell: _____

Address: _____

City: _____ State: ____ Zip: _____ E-mail: _____

Pediatrician: _____ Phone: _____

In case of emergency, please call:

Name: _____ Phone: _____ Relationship: _____

Your child's medical information may be discussed with:

Name: _____ Relationship: _____

Parents are: ❑ Married ❑ Living together ❑ Separated ❑ Divorced ❑ Other

May we leave a message on your phone about your child's medical information? Yes ❑ No ❑

How did you hear about us? _____

PRESENT HEALTH

Please list any of your child's health concerns and/or current diagnosis

1. _____
2. _____
3. _____
4. _____
5. _____

What are your goals for your child in coming to see us today?

_____

_____

Please list any medications, vitamins or over the counter products you give to you child:

_____

_____

Does he/she have any known allergies? No ❑ Yes ❑ _____

Please list any childhood illnesses, accidents, surgeries or injuries and age at occurrence:

_____

Any complications or concerns regarding pregnancy and childbirth?

_____

Has your child been breast fed? No ❑ Yes ❑ How long? _____

Has your child been vaccinated? No ❑ Yes ❑

Has your child had: ❑ X-Ray ❑ CAT scan ❑ MRI Please describe: _____

What are your child's favorite hobbies and activities:_____

_____

What are your child's favorite foods?_____

_____

What type of pets do you own?_____

How would you rate your child's academic performance?_____

Is there anything else you would like us to know about your child?

_____

_____

_____

Please indicated if your child has or has had the following:

- ❑ Eczema or psoriasis
- ❑ Diarrhea
- ❑ Constipation
- ❑ Finicky eating
- ❑ Chronic Sniffles
- ❑ Hyperactivity
- ❑ Growing Pains
- ❑ Colic
- ❑ Asthma
- ❑ Nightmares
- ❑ Bed-wetting
- ❑ Warts
- ❑ Tantrums
- ❑ Fears/Phobias
- ❑ Stomach Aches

FAMILY HISTORY

	Father	Mother	Grandparent	Sibling	Other (specify)
Anemia	❑	❑	❑	❑	_____
Cancer	❑	❑	❑	❑	_____
Diabetes	❑	❑	❑	❑	_____
Heart Disease	❑	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	❑	_____
Stroke	❑	❑	❑	❑	_____
Epilepsy	❑	❑	❑	❑	_____
Mental Illness	❑	❑	❑	❑	_____
Asthma	❑	❑	❑	❑	_____
Hay Fever, Hives	❑	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	❑	_____
Tuberculosis	❑	❑	❑	❑	_____
Smoke	❑	❑	❑	❑	_____
Alcohol	❑	❑	❑	❑	_____
Age at Death:	_____	_____	_____	_____	_____

FINANCIAL AGREEMENT

Cancellation Policy: Patients will be billed for any appointment cancelled with less than 24 hours notice. There is a $65.00 missed appointment fee.

Phone Consult Policy: Physician on Staff will return phone calls during business hours. Any consultation that exceeds 10 minutes will incur a charge of $45.

I understand that I am wholly and personally responsible for ***payment on date of service***. **Cedar Natural Healthcare** is not a participant in Medicare or insurance plans. I realize that I may request the attending physician's statement of diagnosis and services provided to me, which I may submit to my insurance company for reimbursement of the treatment cost, as may be provided by my plan. **Cedar Natural Healthcare** does not guarantee that I will receive reimbursement from my insurance carrier. I understand that **Cedar Natural Healthcare**, at it's option, may charge me interest on any unpaid balances.

I have read and agree to the financial terms and cancellation policy above:

Patient Signature: _____ Date: _____

INFORMED CONSENT FOR TREATMENT

Common diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
Minor office procedures: e.g., dressing a wound, ear cleaning.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrition.
Botanical medicine: botanical substances my be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring elements to gently stimulate the body's healing responses, given orally, topically or by injection.
Lifestyle counseling and hygiene: promotion of wellness including recommendations for exercise, sleep, contraception, and stress reduction. **Psychological Counseling and /or the ordering of la**b **procedures, referral for x-ray, MRI, or other imaging, thermal imaging.**
Naturopathic manipulation: specific manipulation of muscles and joints or soft tissue.
Naturopathic physiotherapy / hydrotherapy: the use of electromagnetic therapies, water applications, thermal or cryo-applications to stimulate healing.
Prescription of pharmaceuticals and / or bio-identical hormones.
I understand that treatment by a naturopathic doctor is intrinsically different from treatment by a conventional medical doctor. While naturopathic medicine is intrinsically safer than other systems of medicine, there are potential risks in what we do as well. The care we provide may or may not, be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore your body's innate healing ability. We will always strive to provide full disclosure of all information relevant to your health care.
I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, healing reaction as defined below,
inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.
Healing Reaction: Natural healing may occasionally generate a "healing reaction." If this is anticipated, we will offer you specific information about this phenomenon. Generally this will occur as a flu-like state with fever or a worsening of symptoms for a few days. It can also, however be different than this and may require expert attention and guidance.
Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures and that I realize that no guarantees have been given to me by the doctor's or staff of **Cedar Natural Healthcare** 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.

Privacy Notice: Cedar Natural Healthcare is required by law to respect your privacy by following specific HIPPA guidelines. A "Notice of Privacy Practices" document is available upon request.

Patient Signature or Legal Guardian _____ Date: _____

Doctor's Signature: _____ Date: _____