



Trillium Natural Medicine, LLC

naturopathic medicine & acupuncture

3043 West Liberty Ave.  
Pittsburgh, PA 15216  
412.571.9355

**PEDIATRIC INTAKE FORM (6–12 years)**

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_

Telephone # (home): \_\_\_\_\_ Parent's # (work): \_\_\_\_\_

Parent's email address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Female  Male

How did you hear about Trillium Natural Medicine? \_\_\_\_\_

Has any other family member already been a patient at Trillium Natural Medicine? \_\_\_\_\_

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: \_\_\_\_\_

Reason for referral or presenting problems: \_\_\_\_\_

What are your child's most important health problems? List as many as you can in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

Does your child have a contagious disease at this time?  Yes  No

If yes, what? \_\_\_\_\_

**Medications**

Aspirin  Now  Past

Ibuprofen  Now  Past

Tylenol  Now  Past

Antibiotics  Now  Past

Decongestant  Now  Past

Anti-histamine  Now  Past

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

- 1. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 6. \_\_\_\_\_
- 3. \_\_\_\_\_ 7. \_\_\_\_\_
- 4. \_\_\_\_\_ 8. \_\_\_\_\_

**Medical History**

Chicken pox

Scarlet fever

Tonsillitis, approx. no. \_\_\_\_\_

Measles

Pneumonia

Ear Infections, no. \_\_\_\_\_

Mumps

Frequent colds

Other (please list) \_\_\_\_\_

Rubella

Rheumatic fever

Injuries/Surgeries/Hospitalizations (please list): \_\_\_\_\_

Has your child had any of the following tests? 

	When	Where	Results
--	------	-------	---------

Electroencephalogram \_\_\_\_\_

Psychological evaluation \_\_\_\_\_

Hearing \_\_\_\_\_

Speech/Language \_\_\_\_\_

**Immunizations**

- MMR       DPT       Chicken Pox       Hepatitis       Measles       Diphtheria       Small Pox
- Mumps       Tetanus       H. influenza       Rubella       Polio       The Flu       Pertussis

Others (please list): \_\_\_\_\_  
\_\_\_\_\_

Any adverse reactions?     Yes     No

If yes, what? \_\_\_\_\_

**Family History**

Do you have a family history of any of the following (please check)?

- Asthma/Hayfever/Hives       Alzheimer's       Cancer       Diabetes
- Epilepsy Arthritis       Heart Disease       High Blood Pressure       Glaucoma
- Kidney Disease       Mental Illness       Stroke Anemia       Tuberculosis

Any other relevant family history? \_\_\_\_\_  
\_\_\_\_\_

What is your heritage? (for identifying risk factors for disease) \_\_\_\_\_

**Allergies**

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental or chemicals? \_\_\_\_\_

Breast fed?     Yes     No    How long? \_\_\_\_\_    Formula?     Yes     No    Type (milk /soy) other \_\_\_\_\_

**Diet**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

**For the Following, Please Check the Appropriate Response Based on the Key Below:**

**Y**=a condition your child has now      **N**=Never had      **P**=Significant problem in the past

**Review of Systems**

**Mental / Emotional**

- |                            |  |                            |  |
|----------------------------|--|----------------------------|--|
| Mood Swings? .....         | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Anxiety/nervousness? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Irritability? .....        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Cries easily? .....        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Hyperactivity? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Unusual fears? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Introvert/extrovert? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Sleep problems? .....      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Motion/car sickness? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Nightmares? .....          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Endocrine**

- |                              |  |                         |  |
|------------------------------|--|-------------------------|--|
| Heat/cold intolerance? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Fatigue? .....          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Excessive thirst? .....      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Excessive hunger? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Low blood sugar? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | High blood sugar? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Skin**

- |                    |  |                      |  |
|--------------------|--|----------------------|--|
| Rashes? .....      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Eczema, Hives? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Acne, Boils? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Itching? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Head**

- |                     |  |                    |  |
|---------------------|--|--------------------|--|
| Headaches? .....    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Head Injury? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Dizzy Spells? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | High fevers? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Eyes**

- |                            |  |                           |  |
|----------------------------|--|---------------------------|--|
| Glasses or contacts? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Tearing or dryness? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Blurriness? .....          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Eye pain/strain? .....    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Ears**

- |                         |  |                 |  |
|-------------------------|--|-----------------|--|
| Impaired hearing? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Earaches? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
|-------------------------|--|-----------------|--|

**Nose and Sinuses**

- |                       |  |                      |  |
|-----------------------|--|----------------------|--|
| Frequent colds? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Nose Bleeds? .....   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Stiffness? .....      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Hayfever? .....      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Sinus problems? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Loss of smell? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**Mouth and Throat**

- |                             |  |                     |  |
|-----------------------------|--|---------------------|--|
| Frequent sore throat? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Canker Sores? ..... | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |
| Teeth grinding? .....       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P | Breath Odor? .....  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P |

**For the Following, Please Check the Appropriate Response Based on the Key Below:**

**Y**=a condition your child has now      **N**=Never had      **P**=Significant problem in the past

**Respiratory**

Cough? .....  Y  N  P

Wheezing? .....  Y  N  P

Asthma? .....  Y  N  P

Bronchitis? .....  Y  N  P

**Cardiovascular**

Heart disease? .....  Y  N  P

Murmurs? .....  Y  N  P

**Gastrointestinal**

Belching or passing gas? .....  Y  N  P

Stomach aches? .....  Y  N  P

Constipation? .....  Y  N  P

Diarrhea? .....  Y  N  P

Bowel Movements: How often? \_\_\_\_\_

**Urinary**

Pain on urination? .....  Y  N  P

Increased frequency? .....  Y  N  P

Frequency at night? .....  Y  N  P

Inability to hold urine? .....  Y  N  P

Frequent infections? .....  Y  N  P

Kidney stones? .....  Y  N  P

**Musculoskeletal**

Joint pain or stiffness? .....  Y  N  P

Arthritis? .....  Y  N  P

Broken bones? .....  Y  N  P

Weakness? .....  Y  N  P

Muscle spasms or cramps? .....  Y  N  P

Sciatica? .....  Y  N  P

**Blood / Peripheral Vascular**

Easy bleeding or bruising? .....  Y  N  P

Anemia? .....  Y  N  P

Deep leg pain? .....  Y  N  P

Cold hands/feet? .....  Y  N  P

Varicose veins? .....  Y  N  P

Thrombophlebitis? .....  Y  N  P

**Musculoskeletal**

Joint pain/stiffness? .....  Y  N  P

Muscle spasms/cramps? .....  Y  N  P

Broken bones? .....  Y  N  P

**Blood/Peripheral Vascular**

Anemia? .....  Y  N  P

Easy bleeding/bruising? .....  Y  N  P

Is there anything else you would like to add or comment on?

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What expectations do you have for your child from working with our clinic?

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*Thank you. We look forward to helping your child in any way we can.*



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Dear New Patient,

Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

\_\_\_\_\_ Payment for all services and dispensary items is due at the time of the visit.

*Initials*

\_\_\_\_\_ We are not providers on insurance plans, therefore you may be required to bill your own insurance.

*Initials*

We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.

\_\_\_\_\_ You will be charged a Missed Appointment Fee of \$50.00 for any missed appointments or late cancellations (less than 24 hours notice).

*Initials*

\_\_\_\_\_ I give permission for the staff at Trillium Natural Medicine to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

*Initials*

\_\_\_\_\_ I have read Trillium Natural Medicine's Privacy Practices (found on website or in office).

*Initials*

\_\_\_\_\_ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your naturopathic doctor or acupuncturist will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

*Initials*

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$20.00 for every returned check(s).

Your Naturopathic doctor or Acupuncturist may prescribe natural medicine, which may be purchased either at Trillium Natural Medicine or elsewhere. Most insurance companies do not cover the medicinary items that we prescribe and dispense.

I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

\_\_\_\_\_  
Print your name

(parent name if minor & patient name)

\_\_\_\_\_  
Your Signature

(parent signature if minor)

\_\_\_\_\_  
Date



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***Informed Consent and Request for Naturopathic Medical Care,  
Acupuncture & Classical Chinese Medicine Treatment***

As a patient I have the right to be informed about my health condition(s) and to be recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Maureen D. Tighe, N.D., L.Ac., M.S.O.M. having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM) by Dr. Maureen D. Tighe, ND, L.Ac, MSOM and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Maureen D. Tighe, ND, L.Ac, MSOM and/or with the *allied health care provider* providing backup:

1. My suspected diagnosis(es) or condition(s)
2. The nature, purpose, goals and potential benefits of the proposed care
3. The inherent risks, complications, potential hazards or side effects of treatment or procedure
4. The probability or likelihood of success
5. Reasonable available alternatives to the proposed treatment procedure
6. Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms)
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized, disposable, stainless steel, sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical devices including heat lamps
- Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick)

- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

**Potential risks:** Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of the body’s maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

**Notice to individuals with bleeding disorders, pace makers, and/ or cancer:** For your safety it is vital to alert your provider, Dr. Maureen D. Tighe, ND, L.Ac, MSOM of these conditions.

\_\_\_\_\_ I understand that Dr. Maureen D. Tighe, ND, L.Ac, MSOM is not licensed to prescribe any  
*Initials* controlled substances.

\_\_\_\_\_ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic  
*Initials* substances; however these have been used widely in Europe, China and the USA for years.

\_\_\_\_\_ I understand that Dr. Maureen D. Tighe, ND, L.Ac, MSOM is not an MD, psychologist or psychiatrist. She is not  
*Initials* licensed in Pennsylvania to diagnose disease or prescribe pharmaceutical drugs. She can make nutritional, herbal, homeopathic and lifestyle recommendations and can diagnose and treat Chinese medicine patterns of disharmony.

I do not expect Dr. Maureen D. Tighe, ND, L.Ac, MSOM and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Maureen D. Tighe, ND, L.Ac, MSOM explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

\_\_\_\_\_  
 Printed Name of Patient

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Printed Name of Guardian

\_\_\_\_\_  
 Signature of Guardian

\_\_\_\_\_  
 Date Signed

\_\_\_\_\_  
 Print Provider’s Name