

Trillium Natural Medicine
Naturopathic Medicine & Acupuncture
3043 West Liberty Ave.
Pittsburgh, PA 15216
(412) 571-9355

PEDIATRIC INTAKE FORM (6-12 years)

Name: _____ Date: _____
Age: ____ Date of Birth: ____/____/____ Female: ____ Male: ____
Mother's name: _____ Father's name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone # (home): (____) _____ Parent's # (work): (____) _____
Parent's e-mail address: _____
How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

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

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

Does your child have a contagious disease at this time? Y N
If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Has your child had any of the following tests? When Where
Electroencephalogram (EEG)

.....
Psychological evaluation

.....
Hearing tests

.....
Speech/Language tests

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ?	_____

Allergies

Is your child hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmental? _____
Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

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) _____ |

REVIEW OF SYSTEMS

Y = a condition now P = significant problem in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
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NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N
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URINARY

Frequent urination Y P N Bed wetting Y P N

GASTROINTESTINAL

Belching/passing gas Y P N Stomach aches Y P N
Constipation Y P N Diarrhea Y P N
Bowel Movements How often _____

MUSCULOSKELETAL

Joint pain/stiffness Y P N Muscle spasms/cramps Y P N
Broken bones Y P N

BLOOD/PERIPHERAL VASCULAR

Anemia Y P N Easy bleeding/bruising Y P N

Is there any information about your child's health that you would like to add?

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

Thank you for taking the time to fill out this form.

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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. Please initial below to indicate that you have read and agree to the policies below.

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

_____ We are not providers on insurance plans, therefore you may want to submit your own claim for reimbursement. We will provide you with all the necessary information for you to send your claim as you have the primary relationship with your insurance company.

_____ Out of courtesy for our wait list patients, if you are unable to make your appointment, please call the office to cancel your appointment at least 24 hours in advance. This allows us to provide care to our patients that need our services as soon as possible. If you fail to comply you will be responsible for your office visit payment in full.

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

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). We do arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at Trillium Natural Medicine. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at Trillium Natural Medicine.

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.

Your Signature (parent signature if minor) Date

Print your name (parent name if minor & patient name)

Trillium Natural Medicine, 3043 West Liberty Ave., Pittsburgh, PA 15216

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 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. and/or Yasmin Fakih, L.Ac. 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, Yasmin Fakih 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, Yasmin Fakih, L.Ac. 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)
- Trigger point injection therapy with vitamin substances
- 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, may include transcutaneous electrode stimulation)
- 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, mechanical and magnetic devices
- 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)

