Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105 Honolulu, HI 96814 808.591.8778

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS OLD)

Patient's Name:_____Date:_____
Age: _____ Date of Birth: _____Gender: Female / Male
Parent/Guardian's Name: _____
Address:_____City:_____State:_____Zip:_____
Telephone (home): _____(Parent's work): _____
Parent's email address:_____
How did you hear about this clinic? _____
Has any other family member already been a patient at this clinic?_____
Name of doctor's office/hospital/clinic where your child's health records are kept:
_____
Reason for referral or presenting problems:

_____

MEDICATIONS

☐ Aspirin ☐ Decongestants
☐ Tylenol ☐ Anti-histamine
☐ Antibiotics ☐ Other: _____
☐ Ibuprofen ☐ Allergies to medicines:_____

MEDICAL HISTORY

☐ Chicken pox ☐ Scarlet fever ☐ Tonsillitis, approx no. of times: _____
☐ Measles ☐ Pneumonia ☐ Ear infections, approx no. of times: _____
☐ Mumps ☐ Frequent colds ☐ Strep throat, approx no. of times_____
☐ Rubella ☐ Rheumatic fever ☐ Other:_____

Has your child ever had any of the following?
Electroencephalogram (EEG):_____Psychological evaluations:_____
Hearing test:_____Speech/language tests:_____
Injuries/surgeries/hospitalizations (please list):_____

IMMUNIZATIONS

Chicken pox	Measles	Diphtheria
Small pox	MMR	DPT
Others:	Mumps	Tetanus
H. influenza	Rubella	Polio
Adverse reactions? If Yes, what?		

FAMILY HISTORY

☐ Heart disease ☐ Diabetes ☐ Birth defects
☐ Hypertension ☐ Arthritis ☐ Tuberculosis
☐ Cancer ☐ Allergies ☐ Asthma
☐ Mental illness ☐ Osteoporosis ☐ Other significant:_____

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PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

_____

Mother's age at child's birth: _____ Mother's health during pregnancy:_____

☐ Bleeding ☐ Illnesses ☐ Nausea ☐ Physical or emotional trauma
☐ Hypertension ☐ Cigarettes, alcohol, drug consumption
☐ Medications ☐ Diabetes ☐ Thyroid problems

BIRTH HISTORY

☐ ☐ ☐

Term: Full / Premature / Late Length of labor:_____Complications:_____
Birth city & state:_____Birth time:_____ Birth weight: _____

Did you child have any of the following problems shortly after birth?

☐ Rashes ☐ Jaundice ☐ Birth injuries ☐ Blue baby ☐ Seizures ☐ Cerebral palsy
☐ Colic ☐ Fever ☐ Birth defects
☐ Other: _____

Child's sleep patterns (1st year):_____
Food intolerances:_____
Breast fed: Y / N How long:_____Formula: Y / N Type (milk, soy): _____
Age began solids:_____Which foods:_____
Age began: Sitting _____Crawling _____Walking_____Talking_____

SYMPTOMS

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

Hives	Burning urine	Bloody urine	Eczema
Cries easily	Bleeding gums	Heart murmur	Nervous
Nose bleeds	Vomiting spells	Sleep problems	Asthma
Acne	Anemia	Night sweats	High fevers
Jaundice	Sensitive to light	Chronic rash	Stomach aches
Diarrhea	Hearing loss	Easy bruising	Sore throats
Flat feet	No appetite	Body/breath odor	Constipation
Nightmares	Frequent colds	Bleeding tendency	unusual fears
Wheezing	Joint pains	Dizzy spells	Hair loss
Excessive fatigue	Cough	Allergies	Frequent urination

DIET

Please describe your child's typical daily diet:

_____
_____
_____
_____

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Acknowledgment & Agreement of Terms

Our goal is to assist you in achieving improved health. We shall work with your body's inherent ability to heal encompassed in the laws of nature.

This agreement clarifies our billing procedures. Please carefully read the statements below. Your signature designates your understanding and consent to these procedures. Please contact us with any questions, if necessary, prior to returning this form.

1. All accounts are due at the time of your visit. Cash, check, MasterCard, and Visa are acceptable methods of payment.

2. It is your responsibility to determine whether or not your insurance company will reimburse you for your visit(s), and to what degree. We provide the proper paperwork, so that you may correspond with your insurance company directly.

3. Services and treatments not covered by your insurance carrier will still be your personal responsibility for payment to Dr Karen Tan.

4. We provide adjunctive, ongoing care. This means that care rendered by our physicians will not replace your need for a primary care physician. Our physicians subscribe to no hospital plans in the area, and therefore do not have admitting privileges.

5. The fee for an initial consultation, which includes a detailed history, physical exam, and a treatment program is **$210**. Return visits are **$110**. These fees are subject to change without prior notice.

6. If you have HMAA or UHA, you will be responsible for the co-pay as well as the portion of the above stated fees that is not covered by your insurance. Please provide a copy of your insurance card and fill out the insurance claim form.

7. A 24 hour notice is required if you cannot make the next scheduled appointment. If you change or cancel the appointment within 24 hours, you will be charged for the visit.

Signature:_____ Date:_____

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Informed Consent

In signing below, I acknowledge that Karen Tan, ND, MAcOM, LAc, has disclosed to me the following items concerning my treatment:

1. The care being provided is not a treatment for a specific disease, but preventative in nature and designed to improve my health or condition.

2. That she is not recommending I discontinue any other treatment or care being provided by any other health care professional.

3. That there is no guarantee or warrantee, expressed or implied, concerning the outcome of any procedures.

4. That full disclosure of information has been made regarding my condition, the nature and character of the proposed treatment and/or procedure, the anticipated results, and the recognized serious possible risks, complications, if any, and anticipated benefits involved in the treatment and/or procedure, and in the recognized possible alternative forms of treatment, including non-treatment.

5. That I have had any questions answered to my satisfaction regarding my treatment, and I have agreed to the treatment and/or procedures that Dr. Tan will provide.

6. That should I experience any difficulties regarding my treatment, I am to contact Dr Tan as soon as possible, or proceed to the nearest emergency room.

Signature:_____ Date:_____