Center for Innovative Medicine
Karen Tan, ND, MAcOM, LAc.
1150 South King Street Suite 905 Honolulu HI 96813 (808) 591-8778

PEDIATRIC INTAKE FORM (6-12 years old)

Name:_____Date: _____

Age: _____ Date of Birth: ____/_____/_____ Sex (circle): Female/Male

Mother's name:_____Father's name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Phone # (home): (____)_____ Parent's # (work): (____)

Email address: _____

How did you hear about our clinic?

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: _____Birth time: _____Birth weight:_____

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

_____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 had any of the following tests?

Electroencephalogram (EEG)_____

Psychological evaluation_____

Hearing tests_____

Speech/Language tests_____

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Hospitalizations/Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had

_____

_____

Immunizations

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

Allergies or Hypersensitivies

Any drugs?_____
Any foods? _____
Any environmentals?_____
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)_____

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REVIEW OF SYSTEMS

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

MENTAL/ EMOTIONAL			
Mood Swings	Y N P S	Irritability	Y N P S
Anxiety/nervousness	Y N P S	Unusual fears	Y N P S
Hyperactivity	Y N P S	Introvert/extrovert	Y N P S
Cries easily	Y N P S	Motion/car sickness	Y N P S
Nightmares	Y N P S	Sleep problems	Y N P S
NOSE AND SINUSES			
Frequent colds	Y N P S	Nose Bleeds	Y N P S
Stuffines	Y N P S	Hayfever	Y N P S
Sinus problems	Y N P S		
MOUTH AND THROAT			
Breath odor	Y N P S	Frequent sore throat	Y N P S
Canker sores	Y N P S		
ENDOCRINE			
Heat/cold intolerance	Y N P S	Fatigue	Y N P S
Excessive thirst/hunger	Y N P S	High blood sugar	Y N P S
Low blood sugar	Y N P S		
RESPIRATORY			
Cough	Y N P S	Wheezing	Y N P S
Asthma	Y N P S	Bronchitis	Y N P S
CARDIO-VASCULAR			
Heart disease	Y N P S	Murmurs	Y N P S
SKIN			
Hives	Y N P S	Acne	Y N P S
Eczema	Y N P S	Itching	Y N P S
Rashes	Y N P S		
URINARY			
Frequent urination	Y N P S	Bed wetting	Y N P S
HEAD			
Headaches	Y N P S	Head Injury	Y N P S
Dizzy spells	Y N P S	High fevers	Y N P S
GASTRO-INTESTINAL			
Stomach aches	Y N P S	Belching/passing gas	Y N P S
Constipation	Y N P S	Diarrhea	Y N P S
Bowel Movements		How often?	
EYES			
glasses/contacts	Y N P S	tearing or dryness	Y N P S
eye pain/strain	Y N P S		
MUSCULOSKELETAL			
joint pain/ stiffness	Y N P S	muscle spasms	Y N P S
cramps	Y N P S	broken bones	Y N P S
EARS			
earaches	Y N P S	impaired hearing	Y N P S
BLOOD			
Anemia	Y N P S	Easy bleeding	Y N P S
easy bruising	Y N P S		

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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?

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Acknowledgement & 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 **$350 + tax**. Return visits are **$150 + tax**. 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. **Rescheduling & Cancellation Policy:** A 48 hour notice is required if you need to reschedule or cancel your scheduled appointment(s). If you change or cancel the appointment less than 48 hours of your scheduled appointment time, your credit card will be automatically charged for the visit.

Signature:_____ Date:_____

Karen Tan ND MAcOM LAC LLC
1150 South King St Suite 905, Honolulu, HI 96814 (808) 591-8778

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 warranty, 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:_____