**Amanda H. Fey, ND**
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697
27 Jenison Avenue Johnson City, NY 13790 Ph. (607) 729-0591

Hello and Welcome!

Attached you will find pediatric intake forms. Before your child's scheduled appointment, please fill out the forms as thoroughly as possible. I know your time is valuable and by bringing your already completed intake forms with you will maximize the time spent at your health visit.

Your child's first visit will consist of a thorough assessment of his/her health history lasting between 45 minutes to an hour. *Please bring copies of any recent lab work, as well as any supplements or medications your child is currently taking.*

If you are unable to keep your child's scheduled appointment for any reason, please let us know so we can reschedule his/her visit at a more convenient time. A 24-hour notice is greatly appreciated.

I truly look forward to working with you and your child on the journey towards optimal health.

Warmly,
Amanda H. Fey, ND

**Amanda H. Fey, ND**
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697
27 Jenison Avenue Johnson City, NY 13790 Ph. (607) 729-0591

## NEW PEDIATRIC INTAKE FORM (0-12 years old)

Date___________ Child's name________________________________________

Date of Birth____________ Age______ Gender: Male or Female

Address:________________________________________________________
STREET OR PO BOX CITY, STATE, ZIP

Phone: Home__________________________ Work/Cell____________________________

Mother's Name:________________________ Father's Name: ________________________

If parents are separated, child primarily lives with:________________________________

Emergency contact-name, phone, relationship_____________________________________

How did you hear about our clinic?______________________________________________

### HEALTH HISTORY

What are your child's most important health concerns? List them in order of importance

1.__________________________________ Date of Onset__________________________

2.__________________________________ Date of Onset__________________________

3.__________________________________ Date of Onset__________________________

4.__________________________________ Date of Onset__________________________

5.__________________________________ Date of Onset__________________________

Is your child currently receiving healthcare for his/her concerns? □ Yes □ No
If yes, where and from whom?____________________________________________

If no, when and where did you last receive medical or health care? What was the reason?
______________________________________________________________________

| Previous Hospitalizations/Surgeries | Reason | Date |
|---|---|---|
| | | |
| | | |
| | | |

How would you describe your child's overall state of health (please circle)?
Excellent Good Average Fair Poor

### PREVIOUS ILLNESSES

| | | | | | |
|---|---|---|---|---|---|
| Measles | Y | N | Rheumatic Fever | Y | N |
| Chicken Pox | Y | N | Rubella | Y | N |
| Mononucleosis | Y | N | Tonsillitis | Y | N |
| Mumps | Y | N | Ear Infections | Y | N |
| Pneumonia | Y | N | Seizures | Y | N |

**Amanda H. Fey, ND**
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697
27 Jenison Avenue Johnson City, NY 13790 Ph. (607) 729-0591

**ALLERGIES**
Does your child have any allergies to drugs, food, or to the environment (animals, dust, mold, etc)
□ No □ Yes If yes, please indicate what allergies and how he/she was tested:
______________________________________________________________________

**VACCINATIONS**

| | | | |
|---|---|---|---|
| □ Diptheria | □ Measles/Mumps/Rubella | □ Pertussis | □ Chicken Pox |
| □ Tetanus | □ Hepatitis B | □ Polio | □ Pneumococcal |
| □ HiB | □ Influenza | □ Other______________________ | |

**TYPICAL FOOD INTAKE**
Breakfast:______________________________________________________________

Lunch:______________________________________________________________

Dinner:______________________________________________________________

Snacks:_______________________________________________________

Beverages:______________________________________________________________

Breast fed?________________ How long?________________Formula (type)?____________

Were there any trouble introducing foods as infant? If yes, which foods and what were the

difficulties?______________________________________________________________

**CURRENT MEDICATIONS**
Please list all current prescription medications and over the counter medications:

1. ____________________________Dose______________Indication_________________

2. ____________________________Dose______________Indication_________________

3.____________________________Dose______________Indication_________________

4.____________________________Dose______________Indication_________________

How many courses of antibiotics has your child had in the past 10 years?______________________

**CURRENT SUPPLEMENTS**
Please list all current supplements including herbs, vitamins, and/or other supplements:
1. ____________________________Dose______________Indication_________________

2. ____________________________Dose______________Indication_________________

3. ____________________________Dose______________Indication_________________

4. ____________________________Dose______________Indication_________________

**Amanda H. Fey, ND**
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697
27 Jenison Avenue Johnson City, NY 13790 Ph. (607) 729-0591

## FAMILY HISTORY

Please indicate if any family member has/had any of the following:

| | Family member | | Family member |
|---|---|---|---|
| Cancer | ____________ | Autoimmune Disease | ____________ |
| Heart Disease | ____________ | Asthma/Allergies | ____________ |
| Diabetes | ____________ | Celiac Disease | ____________ |
| Depression/Anxiety | ____________ | Hypertension | ____________ |
| Mental Illness | ____________ | Bleeding disorders | ____________ |

## REVIEW OF SYSTEMS N = Now P = Past

**MENTAL/EMOTIONAL**

| | | | | | |
|---|---|---|---|---|---|
| Irritability | N | P | Mood swings | N | P |
| Anxiety/nervousness | N | P | Hyperactive | N | P |
| Poor concentration | N | P | Unusual fears | N | P |
| Sleep problems | N | P | Nightmares | N | P |
| Cries easily | N | P | Introvert/Extrovert ____________ | | |
| **SKIN** | | | | | |
| Rashes | N | P | Acne or Boils | N | P |
| Itching | N | P | Eczema/Hives | N | P |
| **HEAD** | | | | | |
| Headaches | N | P | Dizzy spells | N | P |
| Head Injury | N | P | High Fevers | N | P |
| **EYES** | | | | | |
| Glasses or contacts | N | P | Tearing or dryness | N | P |
| Eye pain/strain | N | P | | | |
| **EARS** | | | | | |
| Impaired hearing | N | P | Earaches | N | P |
| **NOSE & SINUSES** | | | | | |
| Frequent Colds | N | P | Nose Bleeds | N | P |
| Hay fever | N | P | Stuffiness | N | P |
| Sinus Problems | N | P | Loss of Smell | N | P |
| **MOUTH & THROAT** | | | | | |
| Frequent sore throat | N | P | Canker sores | N | P |
| Bleeding gums | N | P | Breath odor | N | P |
| **RESPIRATORY** | | | | | |
| Cough | N | P | Asthma | N | P |
| Wheezing | N | P | Bronchitis | N | P |
| **CARDIOVASCULAR** | | | | | |
| Heart Disease | N | P | Murmurs | N | P |
| **GASTROINTESTINAL** | | | | | |
| Diarrhea | N | P | Constipation | N | P |
| Belching/ Gas | N | P | Stomachaches | N | P |
| Bowel Movements: | How many/day?_______ | | Is this a change?____________ | | |
| **URINARY** | | | | | |
| Frequent urination | N | P | Kidney stones | N | P |
| Frequent infections | N | P | Bed wetting | N | P |
| **MUSCULOSKELETAL** | | | | | |
| Joint pain/stiffness | N | P | Muscle spasm/cramps | N | P |
| Broken bones | N | P | | | |

**Amanda H. Fey, ND**
301 West State Street Ithaca, NY 14850 Ph.(607) 275-9697
27 Jenison Avenue Johnson City, NY 13790 Ph. (607) 729-0591

**BLOOD/PERIPHERAL VASCULAR**

| | | | | | |
|---|---|---|---|---|---|
| Easy bruising/ bleeding | N | P | Anemia history | N | P |

**ENDOCRINE**

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

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

______________________________________________________________________

______________________________________________________________________

**Payment Policy Agreement**

By signing below, you understand that full payment for all services and products you receive from Amanda H. Fey, ND is required at the time of service. MasterCard, VISA, Debit cards, checks, and cash are accepted. You understand that there will be a $25.00 charge for each returned check. You understand that you will be charged a fee of 50% of office visit for any missed appointments or any cancellations less than 24 hours ahead of your scheduled visit.

Signature of Patient or Guardian:______________________________Date:__________

Printed Name:______________________________________________

**Consent Form and Agreement**

By signing below, you recognize and understand that Amanda H. Fey, ND is a Doctor of Naturopathic Medicine licensed in the state of Oregon; and therefore, is not licensed to practice medicine in the state of New York. Further, you recognize and understand that she does not diagnose, write, or change pharmaceutical prescriptions. Nutrition and natural health services do not replace the role of a conventional physician. Amanda H. Fey, ND is using her education and experience to give you suggestions about your health. You assume the responsibility for the decision to use a natural remedy. If you feel that you are experiencing any adverse reactions then you understand to stop all supplements immediately.

Signature of Patient or Guardian:______________________________Date:__________

Printed Name:______________________________________________

**Notice of Privacy Practices**

By signing below, you give permission to the staff or the doctor to contact you by telephone and they may leave a message that may contain appointment or medical information if you are not available. You understand that you have the right to inspect and/or copy my health information. Requests to disclose your health information to another health care provider should be provided in writing, unless it is an emergency situation.

Signature of Patient or Guardian:______________________________Date:__________

Printed Name:______________________________________________