Center for INNOVATIVE MEDICINE

Pediatric Intake Form

(6-12 years old)

Karen Tan ND, LAc, MAcOM
1150 South King Street, Suite 905
Honolulu, HI 96814
(808) 591-8778

PERSONAL INFORMATION

Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____ **Gender:** _____

Mother's name: _____ **Father's name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone # (home): _____ **(Parent's # Work):** _____

Email address: _____

How did you hear about this clinic? _____

MEDICATIONS

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? ☐ **Yes** ☐ **No**

If yes, what? _____

PREVIOUS ILLNESSES

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

Has your child ever had any of the following?

Electroencephalogram (EEG): _____ **Psychological evaluations:** _____

Hearing test: _____ **Speech/language tests:** _____

Injuries/surgeries/hospitalizations (please list): _____

HOSPITALIZATIONS/SURGERIES/INJURIES

What hospitalizations, surgeries or injuries has your child had

IMMUNIZATIONS

- ☐ **Chicken pox**
- ☐ **Small pox**
- ☐ **Others:** _____
- ☐ **H. influenza**
- ☐ **Measles**
- ☐ **MMR**
- ☐ **Mumps**
- ☐ **Mumps**
- ☐ **Diphtheria**
- ☐ **DPT**
- ☐ **Tetanus**
- ☐ **Polio**

Adverse reactions? If Yes, what? _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

Breast fed: ☐ **Yes** ☐ **No** **How long:** _____ **Formula:** ☐ **Yes** ☐ **No** **Type (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=Yes/condition you have now **N**=No/never had **P**= Problem in the past **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	Y	N	P	S	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					

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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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** (not AMEX) 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. The fee for an initial consultation, which includes a detailed history, physical exam, and a treatment program is **$425 + tax**. Return visits are **$180 + tax**. Initial Allergy Assessment is **$225 + tax**, subsequent allergy treatments are **$135 + tax**. These fees are subject to change without prior notice.

5. 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.

6. **Rescheduling & Cancellation Policy: A 24 hour notice is required** if you need to reschedule or cancel your scheduled appointment(s). If you change or cancel the appointment less than 24 hours of your scheduled appointment time, your credit card will be automatically charged for the visit.

Signature: _____ Date: _____

NO SHOW AND LATE CANCELLATION POLICY

Please see complete policy for more details. Clinic hours are Monday, Tuesday, Thursday and Saturdays. We are closed on Wednesdays and Fridays. A 24-hours business day notice for canceled or rescheduled appointments (e.g., notice of cancellation for a Monday appointment needs to be given on the Friday before) is necessary in order to avoid being charged. All cancellations need to be called into the clinic. If you are more than 30 minutes late, we will not be able to provide treatment and you will be charged for the treatment session.

Intial: _____ Yes, I have read the cancellation policy.

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. 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.

7. 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.

Signature: _____ Date: _____

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