

Westchester Center for Natural Health
Dr. Angelica Lemke, ND

Patient Information

Last Name: _____ First Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Home Ph:(_____) _____ Work Ph:(_____) _____ Cell Ph:(_____) _____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes (specify): Home Work Cell

Address: _____ City: _____ State: _____ Zip Code: _____

e-mail address: _____ Is e-mail a good way to correspond with you? No Yes

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #: (_____) _____ Home Work Cell Do you have special needs?: No Yes (see front desk)

Do you have a primary care provider? Yes No If so, what is the name of your primary doctor? _____

How did you hear about us? Magazine Ad Mailer/Flyer Website Workshop/Event Friend/Family
 Yellow Pages Other _____ Medical Referral from: _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature Date

Terms of Admission

Financial Terms: I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. The Westchester Center for Natural Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call us at (914) 747-1647.

I hereby acknowledge that I have received a copy of The Westchester Center for Natural Health's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that The Westchester Center for Natural Health has made a good faith effort to obtain my acknowledgement.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature Date

Relationship to Patient/Representative Authority

(version 9-22-09)

CONSENT FOR TREATMENT

I hereby authorize all private practitioners at [the Westchester Center for Natural Health](#) to perform the following specific procedures as necessary to facilitate my treatment:

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Homeopathy/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, highly dilute quantities of a naturally occurring substance, may also be used.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue Therapy (use of hydrotherapy and craniosacral therapy)

Potential Risks: Pain, discomfort, allergic reactions to prescribed herbs or supplements; soft tissue aggravations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the private practitioners at the Westchester Center for Natural Health . I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Guardian/Personal Representative's Name (PRINT)

Patient's Name (PRINT)

Guardian/Personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

Date

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CHILD INTAKE FORM

GENERAL

Name:		Date of 1 st Visit:		
Date of Birth: dd /mm /yyyy	Age:	Gender:	Height:	Weight:
Person completing this form:				
Name of Guardian:		Relationship:		
Name of Guardian:		Relationship:		
With whom does this child live?				
Was this child adopted?		If yes, at what age?		

HEALTH HISTORY

Reason for visit (list in order of importance):

How long has the child had this condition:

What type of therapies have you tried in the past for these concern(s)?

- Diet Modification
 Vitamins/minerals
 Herbs
 Homeopathy
 Chiropractic
 Pharmaceuticals
 Psychological Therapy
 Other _____

What was the outcome? _____

Please list all prescriptions, over the counter medications, supplements, vitamins or natural health products the child is **currently** taking, the reason why, and for how long they have been taking them:

Medication/Natural Health Product	Reason Taking	How long

How many times has the child been treated with antibiotics? _____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year	Illness, Surgery, Injury, Major Medical Diagnosis
_____	_____
_____	_____

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Please list all allergies/sensitivities: (food, environmental, medications, etc)

Please list any other foods that are excluded from the child's diet:

Please check all of the following conditions that your child is currently experiencing (C) or has experienced in the past (P)

Condition	C	P	Condition	C	P	Condition	C	P
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rashes/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Coughing/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Colic/gas/cramping	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>

VACCINATION HISTORY

Is your child fully vaccinated? YES NO

Please indicate if your child experienced any reaction or illnesses following a vaccination. Please indicate what the reaction was and to which vaccination(s) _____

FAMILY HISTORY

Please check any the following that a family member has experienced:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autoimmune (MS, Lupus, etc) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other _____ |

PRENATAL HISTORY

Maternal age for the pregnancy: _____ Paternal age for the pregnancy: _____
 Number of previous pregnancies: _____ Miscarriages: _____ Abortions: _____

Please describe any problems with conception or pregnancy for this child

Please indicate the general health/well-being of the parents during the pregnancy:

- Mother: excellent good fair poor unknown
 Father: excellent good fair poor unknown

Please indicate the general emotional well being of the parents during the pregnancy:

- Mother: excellent good fair poor unknown

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Father: excellent good fair poor unknown

How was the mother's diet during pregnancy?
 excellent good fair poor unknown

EARLY CHILDHOOD HISTORY

Birth Weight: _____

Please indicate if any of the following interventions were applied:

Induction Forceps Vacuum extraction C-section
 Episiotomy Pitocin Pain medication Epidural
 Antibiotics Other _____

Were there any birth complications? (ie breech) _____

How long was the labor? _____

Please indicate if any of the following were present shortly after birth:

Infections/Fever Respiratory Distress Jaundice Poor feeding Anemia
 Congenital Defects Colic Rashes Seizures Birth Trauma/Injuries
 Other: _____

DEVELOPMENTAL AND SOCIAL HISTORY

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____

Were there any difficulties associated with teething? _____

Is your child in: school daycare homecare other What grade level? _____

General school/daycare behaviour/performance: _____

How is the child's behaviour at home? _____

Does your child have any habits? _____ Any fears? _____

Child's interests and favourite activities: _____

How many hours/week does your child: Play on the computer or video games? _____ Exercise? _____
Watch television? _____ Read?(not for school) _____

LIFESTYLE HABITS

What time does your child usually go to bed? _____ Wake up? _____

Does your child nap during the day? Y / N What time(s): _____

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Does your child have nightmares? Y / N How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc)

Was the child breastfed? _____ For how long? _____

Was the child formula fed? _____

Please note any problems with or reactions to feeding: _____

When was solid food introduced? _____

Please describe your child's eating behaviours (eg. Good appetite, picky eater, etc.)

Does your child have any strong food cravings or aversions? _____

Is the child exposed to any of the following on a regular basis?

tobacco smoke pets old building renovations chemical fumes new building

THESE ARE SOME EXAMPLE QUESTIONS THAT WILL BE ASKED THAT YOU CAN CONSIDER

- 1) Does your child need to be held alot or does she resist being held and sqirms around alot?
- 2) Is your child very shy of strangers or connect well with strangers?
- 3) When you hold your child, what positions does your child like? facing inwards, outwards, over the shoulder?
- 4) With infections/colds, how does your child react?
- 5) What are the exact sx's of infections - do you see any redness or swelling? is there discharge? fever?
- 6) Explain details of GI symptoms like diarrhea, constipation, colic, gassiness? what are stools like?
- 7) Are there skin issues and are they dry and scaley, weepy, bright red, itchy?
- 8) Is your child happy, irritable, weepy, angry, anxious etc. And what kinds of things do you notice make your child happy, irritable, weepy, angry, etc.
- 9) Is sleep restless or good? alone or with parents? does your child sleep alot or not alot?
- 10) Is your child warm and sweaty? or prefer being bundled up?
- 11) What is your child's sleeping position (back, side, belly)