

Chaney Integrative Family Medicine

2000 West 47th Place

Westwood, KS 66205

Tel (816) 588-2220 Fax (816) 268-4599

PATIENT INFORMATION (CHILD)

NAME _____ BIRTH DATE _____ AGE ____ SEX M F SS# _____

MOTHER'S NAME _____ FATHER'S NAME _____

HOME ADDRESS _____ HOME ADDRESS _____
CITY _____ ZIP _____ CITY _____ ZIP _____

MOTHER'S HOME PHONE _____ FATHER'S HOME PHONE _____

WORK PHONE _____ WORK PHONE _____

OCCUPATION _____ OCCUPATION _____

SIBLINGS _____ AGES _____ GENDER _____

HOW DID YOU HEAR ABOUT DR. CHANEY? _____ E-mail ADDRESS _____

PLEASE LIST YOUR HEALTH CONCERNS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL HISTORY

Please check any of the following that apply and note when they started

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Frequent Antibiotic Use | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent High Fevers (>102°F) | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Steroid Use | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Awkwardness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bladder/Urinary Tract Infections | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever/Scarlatina |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes/Cold Sores | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Social immaturity |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Talkativeness |
| <input type="checkbox"/> Colitis/Crohn's Disease | <input type="checkbox"/> Inactivity | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Inconsistency | <input type="checkbox"/> Thumb Sucking |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Irritability | <input type="checkbox"/> Until what age? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Tubes in ears |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Left/Right Confusion | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Listlessness | |
| <input type="checkbox"/> Exposure to Toxic Substances | <input type="checkbox"/> Lyme Disease | |

Other: _____

Review of Systems

Please indicate the following N= a condition you have NOW P= a condition you have had in the PAST

| | | |
|---|--|--|
| Skin Dry _____ Oily _____ Itching _____ Rashes _____ Hives _____ Fungal Infections _____ Bruises Easily _____ Slow Healing _____ Warts _____ Moles _____ Where _____ How Many _____ Nails Soft _____ Break _____ | Mouth Dryness ___ Excessive Salivation ___ Tongue: Sore ___ Coated ___ Canker Sores _____ Respiratory Pneumonia _____ Bronchitis _____ Cough _____ Spit up Blood _____ Asthma ___ Wheezing ___ Shortness of Breath _____ Positive TB Test Ever _____ | Muscular/Skeletal Back Pain _____ Pain in Muscles/Joints/Bones _____ Stiffness/Swelling _____ Muscle Weakness/Tremor _____ Numbness/Tingling _____ Shooting Pain _____ Paralysis _____ Any Side Worse: R ___ L ___ Ever Broken Bones? _____ Which _____ Ever Sprained Joints? _____ Which _____ |
| Head Migraines ___ Headaches ___ Location of pain _____ Worse: Light ___ Noise ___ Odors ___ Head Injury _____ Describe _____ Dizziness _____ Fainting _____ Seizures _____ | Cardiovascular Heart Palpitations/Racing _____ Heart Defect _____ Murmur _____ High ___ Low ___ Blood Pressure _____ Leg Pains ___ Cramps ___ Ankle Swelling _____ Cold Hands ___ Feet _____ | GENERAL Energy (scale of 1-10) 1=worst 10=best _____ Best Time of day ___ Worst Time ___ Sleep Good ___ Bad ___ Wake Easily? Y / N Why? _____ Frequently? _____ Difficulty Falling Asleep Y / N Wake Refreshed Y / N Snore Y / N Talk Y / N Grind Teeth Y / N Sleep Walk Y / N Preferred Sleeping Position _____ Nightmares Y / N |
| Eyes Vision Disturbance _____ Dryness ___ Tearing ___ Pain _____ Styes _____ Infections _____ Sensitive to Light _____ | Digestion Bowel Movement _____ X per day: 1-2 ___ 2-3 ___ 3-4 ___ or X per week: 1-2 ___ 2-3 ___ 3-4 ___ Texture: Dry ___ Hard ___ Wet/Loose ___ Pellets ___ Stools with Mucous ___ Blood ___ Hemorrhoids Bleeding ___ Painful ___ Itching ___ Fissures/Fistulas _____ Stool Incontinence _____ Very dark stools _____ Very light stools _____ Bowel Disease _____ Liver/Gallbladder Disease _____ Ulcer _____ Heartburn _____ Bloating _____ Belching _____ Gas / Flatus _____ Nausea / Vomiting _____ Pains / Cramps _____ | Temperature Sensitive to: Hot ___ Cold ___ Both ___ Prefer: Inside ___ Outside ___ Warm blooded ___ Cold blooded ___ Best Season ___ Worst Season ___ |
| Ears Discharge _____ Pain ___ Itch ___ Tubes inserted _____ Impaired Hearing _____ Ringing _____ | Urinary Difficult Urination _____ Painful Urination _____ Incontinence/Dribbling _____ Blood in Urine _____ Frequent Urination Day _____ Night _____ Frequent Bladder Infections _____ Bedwetting _____ | Perspiration Sweat Easily Y / N Sweat Excessively Y / N Sweat Very Little Y / N |
| Nose Seasonal Allergies _____ Drainage _____ Color: Clear ___ Yellow ___ Green ___ Texture: Runny ___ Thick ___ Post Nasal Drip _____ Stiffness _____ Sneezing _____ Sinus Infections _____ Nosebleeds _____ | | Appetite Excessive ___ Good ___ Poor ___ Foods child craves strongly _____ Foods child dislikes strongly _____ Prefers foods Hot ___ Warm ___ Cold ___ Thirst: Excessive ___ Good ___ Poor ___ Prefer drinks: Very Hot ___ Hot ___ Warm ___ Cold ___ Ice cold ___ Recent Weight Change Y / N |
| Throat/Neck Pain in Throat _____ Glands Enlarged _____ Difficult Swallowing _____ Change in Voice _____ Clears Throat Often _____ | | |

Pregnancy

Nausea _____
 Threatened miscarriage _____
 High blood pressure _____
 Preeclampsia _____
 Back pain _____

Birth

Induction (pitocin) _____
 Long or difficult labor or delivery _____
 Please explain: _____
 Prematurity _____
 Child late _____
 Cord around neck _____
 Breech delivery _____
 Caesarian section with prior labor _____
 Scheduled caesarian _____
 Rapid delivery _____
 Drugs during labor _____
 Please list _____

Neonatal

Rh incompatibility _____
 Jaundice _____
 Long time to produce breathing _____
 Weight at birth _____
 Height at birth _____
 Colic _____
 Much crying for no reason _____
 Failure to thrive _____
 Breast fed _____
 How long? _____
 Difficulties with nursing? _____

Development

Periods of separation from mother _____
 If so, when? _____ How long? _____
 Difficulties learning to walk _____
 Difficulties learning to speak _____

Vaccination

Fully vaccinated _____
 Partially vaccinated _____
 Please specify _____

 Not vaccinated _____
 Any unusual vaccines _____
 (e.g. yellow fever, Lyme, smallpox)
 Vaccine reaction _____

Past History

Hospitalization(s): _____

Serious Illnesses and Injuries: _____

Date of Last Physical _____
 Date of Last Blood Tests _____

Personal Family History:

Please check the "yes" box next to each condition that applies to the child or one of his/her family members. Please note whether the condition applies to the patient by writing the word "child" in the relation column. If the condition applies to a family member, please write the relationship to her/him in the relation column (e.g. mother, aunt, sister, father)

| CONDITION | YES | RELATION | PAST (P) / NOW (N) |
|---------------------------|-----|----------|--------------------|
| Alcoholism/Drug Addiction | | | |
| Allergies | | | |
| Alzheimer's | | | |
| Anemia | | | |
| Arthritis | | | |
| Asthma | | | |
| Cancer | | | |
| Type? | | | |
| Depression | | | |
| Diabetes | | | |
| Eczema | | | |
| Epilepsy | | | |
| Headaches | | | |
| Heart Attack | | | |
| Heart Disease | | | |
| Hepatitis | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Kidney Disease | | | |
| Mental Illness | | | |
| Osteoporosis | | | |
| Stroke | | | |
| Suicide | | | |
| Thyroid Disease | | | |
| Tuberculosis | | | |
| Other | | | |

Please list the names of your child's health care providers: _____

Please describe your child's living situation (e.g. divorced parents with joint custody) and any tension at home _____

Please list all prescription and over the counter medications that s/he is currently taking:

| Medication | Dose | Date Started | Prescribed By |
|------------|------|--------------|---------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List vitamins, minerals, herbs, homeopathic remedies that s/he is currently taking:

| Supplement | Dose | Date Started |
|------------|------|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any severe or life-threatening allergies that your child has: _____

Please Explain _____

Personal Habits

| | hours/week (present) | hours/week (past) | | how much? | how long? |
|----------------------|----------------------|-------------------|--------------|-----------|-----------|
| Television | | | Soda | | |
| Computer/Video Games | | | Sweets/Candy | | |
| Video/Movies | | | Coffee/Tea | | |

Does the child have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

Does she/he exercise regularly? Yes No
 What type? _____

Chaney Integrative Family Medicine
DR. AMANDA H. CHANEY, N.D.

FINANCIAL AGREEMENT

Thank you for trusting Chaney Integrative Family Medicine where we are committed to providing the best health care possible. The following statement explains our financial policy. Please read the policy, sign and return to us prior to your treatment. Your payment is due at the time services are provided.

Naturopathic Medicine may be covered by some PPO plans. Please check with your insurance company to determine if this is a covered benefit. Chaney Integrative Family Medicine does not submit billing claims. A superbill will be provided for you to send into your insurance company for reimbursement. Most HMOs do not reimburse for services provided by Naturopathic Physicians.

Returned Checks

For checks returned to us as unpaid by your bank, you will be charged a \$25.00 fee. Any legal fees that we incur to secure past due balances will be added to your account.

Missed Appointments

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge \$25.00 for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me at Chaney Integrative Family Medicine are charged directly to me, and that I am personally responsible for payment on date of service. Chaney Integrative Family Medicine is not a participant in Medicare or HMO insurance plans. Chaney Integrative Family Medicine does not guarantee that you will receive reimbursement from your insurance carrier.

I have read and agree to the financial terms and cancellation policy above.

Date _____ Signature of Patient _____

Signature of Patient Representative or Legal Guardian _____

Relationship to Patient _____

Chaney Integrative Family Medicine
DR. AMANDA H. CHANEY, N.D.

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Amanda H. Chaney of Chaney Integrative Family Medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: Including but not limited to general physical exams, blood, saliva, stool and urine lab work.

Minor office procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplements, intra-muscular and intravenous vitamin/mineral injections.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring elements to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: promotion of wellness, including recommendations for exercise, sleep, contraception and stress reduction.

I understand that treatment by a naturopathic medical doctor is intrinsically different from treatment by a conventional medical doctor. Naturopathic medicine is intrinsically safer than other systems of medicine, though there are potential risks in what we do as well. The care we provide may, or may not, be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore the body's innate healing ability.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, or procedures.

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 as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Chaney Integrative Family Medicine regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Privacy Notice: Chaney Integrative Family Medicine is required by law to respect your privacy by following specific HIPPA guidelines. A "Notice of Privacy Practices" document is available upon request.

Date _____ Signature of Patient _____

Signature of Patient Representative or Legal Guardian _____

Relationship to Patient _____