New Paediatric Patient Intake

Welcome! Holistic health care and preventive medicine are most effective when the doctor has a complete understanding of your child's health history. Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential and will never be shared with any other party. Email addresses will only be used for contact regarding to your child's health care, if necessary.

Name ____ Preferred Name _______________________

Age _____ Date of Birth _____/____/_______ ☐ Female ☐ Male

Email____

Address _____________________________________ Apt. # _________

City ________________________ State ________ Postcode _____________

Home phone _____________________Mobile____________ Is it OK to leave messages? ☐ Yes ☐ No

With whom does this child live? ☐ Mother ☐ Father ☐ Both parents ☐ Other _______________

Emergency contact

Name ____ Relationship _______________

Phone (Day) __________________ (Evening) _________________ (Cell) ___________________

Address ____

Email address ____

Preferred contact ☐ Day phone ☐ Evening phone ☐ Cell phone ☐ Email

Besides the Emergency Contact, who else has permission to bring your child to see Dr. Rozanski?

Name	Phone #	Relationship to child
____	_______________	___________________
____	_______________	___________________

Who may we thank for your referral?

☐ Friend or family

☐ Web search

☐ A Blog or news site

☐ Other ____

Conditions, symptoms, concerns (in order of priority) — Date of onset

(1)____ __________________

(2)____ __________________

(3)____ __________________

(4)____ __________________

Primary Care Physician:

Name ____ Clinic __________________________________

Phone __________________ Address ____

Have you consulted your PCP about the aforementioned condition(s)? ☐ No ☐ Yes

☐ My child does not have a PCP

Other practitioner(s) you have consulted about the aforementioned condition(s):

Name __________________________ Specialty ________________ Clinic ____________________

Phone __________________ Address ____

Diagnosis / treatment / results ____

____

☐ Other practitioners listed on reverse

Have you been to a Natural Medicine Doctor before? ☐ No ☐ Yes

Name ____ City ____________________________

Phone __________________________ Dates of treatment __________________________________

Diagnosis / treatment / results ____

____

Where was your child born? ☐ Hospital ☐ Home ☐ Birth Center ☐ Other ________________

Was your child breastfed? ☐ No ☐ Yes - How long? ____

Please indicate if your child has had the following conditions or symptoms by marking "C" for current, "P" for past, or "N" for never:

C	P	N		C	P	N	
☐	☐	☐	Anemia	☐	☐	☐	Gastrointestinal disorder
☐	☐	☐	Asthma	☐	☐	☐	Hay fever
☐	☐	☐	Autoimmune disease	☐	☐	☐	Headaches
☐	☐	☐	Cancer of ______________	☐	☐	☐	Head injury
☐	☐	☐	Chicken pox	☐	☐	☐	Hypoglycemia
☐	☐	☐	Circulatory problems	☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Constipation	☐	☐	☐	Mononucleosis
☐	☐	☐	Colic	☐	☐	☐	Nausea
☐	☐	☐	Dental problems	☐	☐	☐	Neurological disease
☐	☐	☐	Diabetes	☐	☐	☐	Seizures
☐	☐	☐	Diarrhea	☐	☐	☐	Sinus problems
☐	☐	☐	Difficulty sleeping	☐	☐	☐	Skin problems
☐	☐	☐	Ear infections	☐	☐	☐	Strep throat
☐	☐	☐	Frequent antibiotic use	☐	☐	☐	Urinary tract infection
☐	☐	☐	Frequent colds or flu	☐	☐	☐	Other ________________________

Has you child been immunized? ☐ No ☐ Yes – Please check boxes and list age at vaccination below

☐ DTaP ________________________
☐ HIB __________________________
☐ Hep A ________________________
☐ Hep B ________________________
☐ HPV __________________________
☐ IPV (polio) ___________________
☐ Influenza _________________________
☐ MMR _____________________________
☐ Meningococcal _____________________
☐ Pc (Pnuemonococcal) _______________
☐ Rotavirus _________________________
☐ Varicella _________________________
☐ Other ____________________________

Please list any known allergies:

Drug ____
Environmental ____
Food ____
Other ____

Lifestyle History

Height _______ Weight ________ BMI, if known ________

If your child has daily bowel movements, how many per day? _______
If your child does NOT have daily bowel movements, how many per week? _______
How would you describe them? Color ______________________
Check all that apply: ☐ Easy ☐ Difficult ☐ Painful ☐ Soft ☐ Dry and hard
☐ Loose ☐ Explosive ☐ Blood ☐ Mucus ☐ Undigested food ☐ Floats ☐ Sinks

What does your child regularly eat and drink? Note the typical time of day and describe all that apply:

Breakfast ____
Mid-morning snack ____
Lunch ____
Mid-afternoon snack ____
Dinner ____
Late-night snack ____

Current dietary restrictions ____
Why? ____
Past dietary restrictions ____
When? Why? ____

Where does your child eat? Check all that apply:
☐ Table ☐ Desk ☐ Bed ☐ In front of the TV ☐ Car ☐ Standing ☐ Walking
☐ Other ____

Sleep ______ hours per night
Are there any problems with sleep? ☐ No ☐ Yes ____

Describe your child's physical activity ____
____
____

Is your child exposed to second hand smoke on a regular basis? ☐ No ☐ Yes

Mercury amalgam fillings ☐ Never ☐ Past ☐ Present

Does your child live in a new home or a newly remodeled home? ☐ No ☐ Yes

Do you have pets? ☐ No ☐ Yes ____

Does your child watch television? ☐ No ☐ Yes ___________ hours per day

Major life change in last year? ☐ No ☐ Yes ____

What therapies have you tried? Please check "C" for therapies you currently use and "P" for those you have used in the past:

C	P		C	P	
☐	☐	Acupuncture	☐	☐	Homeopathy
☐	☐	Chiropractic	☐	☐	Oestopathy
☐	☐	Herbal Medicine	☐	☐	Physical Therapy
☐	☐	Detoxification	☐	☐	Jennetics
☐	☐	Mineral Therapy	☐	☐	Supplements
☐	☐	Other ________________________________			

Medications and Supplements

Please list all prescription medications, over-the-counter medicines, natural medicines, vitamins, and supplements your child is currently taking. Use a separate page if necessary.

Name	Dosage	Dates Taken	Reason for taking

☐ See reverse
☐ See attached page

Informed Consent

I, ______________________________ (please print your name clearly), hereby certify by my signature at the bottom of this page that:

I understand Patrick Rozanski is a Doctor of Naturopathic Medicine and Queensland does not recognize naturopathic doctors as licensed medical doctors. I understand that Dr. Rozanski functions as a health consultant and that he is not licensed to diagnose or treat specific diseases, prescribe drugs, or perform surgery in Queensland.

I understand that any assessment performed by Dr. Rozanski and any natural remedy recommended by Dr. Rozanski is for the purpose of optimizing my health, body function, and overall wellness, not for purposes of diagnosis, treatment, or replacement of prescription medication.

I understand that Dr. Rozanski's services are not a replacement for care by licensed medical providers. I understand that Dr. Rozanski advises me to maintain contact with a primary care physician and seek treatment for any symptoms, complaints, and conditions that I feel require such care. I take responsibility for informing other medical providers of any natural remedy I choose to consume. I take responsibility for informing Dr. Rozanski of any changes in my health, medications and supplements while seeking his services.

I take full responsibility for taking any natural remedy Dr. Rozanski may recommend. I do not hold Dr. Rozanski accountable or liable for any adverse effects or complications from the natural remedies that I consume. I understand that results are not guaranteed.

I understand that Dr. Rozanski does not bill insurance and I agree to pay for his services at each visit, unless we have specified a different financial agreement prior to the appointment.

I understand that the internet is an open network and provides no inherent protection for confidential information. If I use email to communicate with Dr. Rozanski I understand that it may pose risks to the confidentiality of my health information and I accept these risks. I understand that there will be times when he does not have access to email and that I must contact him by telephone regarding critical or time-sensitive issues.

I sign this informed consent to express that I voluntarily seek consultation from Dr. Rozanski. I understand that I am free to withdraw my consent and to discontinue participation at any time.

I have read this consent form and fully understand its contents.

Patient name: ______________________________

Date of birth: ______________________________

Parent signature: ______________________________

Date: ______________________________