



Welcome to Gallatin Valley Natural Medicine, office of Dr. Breana McElgunn, N.D. We appreciate the opportunity to provide for your health needs, thoroughly and efficiently, so that you and your family can enjoy the benefits of healthy living. It is our belief that health care is at its best when there is friendly cooperation, mutual understanding, and open communication between a patient and their physician.

Your first visit will include a review of your medical history, a thorough examination if necessary, a consultation and a discussion of your personal health goals. In our practice, we prefer to utilize multiple treatment modalities to effectively and creatively address the causes of your particular health concerns. As part of your visit you will be provided an outline detailing your individual treatment plan.

Patients are seen by appointment only - this time is reserved exclusively for you. A limited number of acute visits are integrated into the weekly schedule to accommodate patients with urgent needs - call for availability. With increasing patient demand and a commitment to personalized attention, we have found it necessary to require a credit card number to guarantee your appointment time. If you should need to change your appointment time we will be happy to do so with 24 hours notice or you will be billed for your missed appointment. As a courtesy, our clinic will attempt to contact you prior to your appointment at the phone number you have provided to remind you of your scheduled visit.

Gallatin Valley Natural Medicine office hours are as follows:

Monday: 9:00 am to 5:00 pm

Tuesday: 9:00 am to 5:00 pm

Wednesday: 1:00 pm to 7:00 pm

Thursday: 9:00 am to 5:00 pm

Payment for services will be expected at the end of your visit; we accept cash, check, MasterCard, Visa, and American Express. Office visits are non-refundable. Unopened supplements will be accepted for refund only within 30 days of the date of purchase. Special order supplements are non-refundable.

If you would like to submit your bill to your insurance provider, we will gladly provide you with a form that will assist you with that process.

Thank you for your trust and confidence that you have placed in our clinic. We look forward to meeting you.

Your Appointment:

Sincerely,

Dr. Breana McElgunn, Naturopathic Physician

2002 North 22nd Ave. Suite 2 * Bozeman, MT 59718 * 406-587-0858 * www.gvnm.info

Please fill out the intake form from the website and bring it with you.

Signature Parent/Guardian: _____ Date: _____

Gallatin Valley Natural Medicine

2002 North 22nd Ave. Suite 2
Phone: (406) 587-0858

Bozeman, MT 59718
Fax: (406) 586-0406

Pediatric Patient Intake (6 - 15 yrs)

By completing this profile of your health history, I can offer you more complete naturopathic care. Please be assured that I keep this information confidential.

Name _____ Parent(s) Name _____ Birth Date _____
Address _____ City & State _____ Zip _____
Social Security # _____ Home Phone _____ Work Phone _____
Email Address _____
How did you hear about me? _____

Where, when, from whom and for what reason did your child last receive health care? _____

What are your current health concerns?

1. _____
2. _____
3. _____

Has your child received any vaccinations? Y N

If yes, which ones, including dates: _____

Any problems with vaccinations? Y N Please explain: _____

Family Health History

Y = Yes

N = No

D = caused death (incl. age)

P = In the past

Please indicate if an immediate family member has had any of the following; if yes, please specify who.

Asthma	Y	N	D	P	_____
Cancer	Y	N	D	P	_____
Cystic Fibrosis	Y	N	D	P	_____
Eczema	Y	N	D	P	_____
Heart Disease	Y	N	D	P	_____
Mental Illness	Y	N	D	P	_____
Obesity	Y	N	D	P	_____
Stroke	Y	N	D	P	_____

Any diagnosed chronic illnesses or frequent acute illnesses? Y N _____

Allergies:

Drugs _____

Environmental _____

Foods _____

Hospitalizations Y N If yes, please list _____

Current prescription medications - _____

Current over-the-counter medications - _____

Current vitamin/herbal supplements - _____

Pregnancy, Labor & Delivery: Home or hospital birth? Any problems? Please explain: _____

Alcohol or drug use during pregnancy? Y N Please explain _____

Gestational Diabetes? Y N Please explain _____

Breastfeeding Y N Duration: _____ Age of weaning _____

Formula Feeding Y N Cow's milk or soy based _____ Duration & Age of weaning _____

Health Conditions Y = Yes N = No P = a condition the child has had in past

Skin
 Rashes Y N P Itching Y N P
 Eczema Y N P Acne Y N P

Head
 Injuries Y N P Forceps delivery Y N
 Headaches Y N P Hair loss Y N P

Eyes
 Lazy eye Y N P Injuries N P
 Glasses Y N Infections Y N P

Ears
 Infections Y N P Discharge Y N P
 Injuries Y N P Hearing problems Y N P
 Ringing Y N P Dizziness Y N P

Nose & Sinuses
 Discharge Y N P Frequent Infections Y N P
 Stiffness Y N P Bleeding Y N P

Mouth, Throat & Neck
 Teething: 1st Tooth _____ months Problems? _____
 Molars _____ months Problems? _____
 Sore throat/tongue Y N P Dental cavities Y N P
 Swollen Glands Y N P Speech problems Y N P
 Neck injuries Y N P Swallowing problems Y N P
 Orthodontics Y N P Bleeding gums Y N P

Heart
 Murmurs Y N P Congenital problems Y N P
 Chest pain Y N P Palpitations Y N P

Respiratory
 Asthma Y N P Coughs Y N P
 Bronchitis Y N P Pneumonia Y N P
 Wheezing Y N P Difficulty breathing Y N P
 Short of breath Y N P 2nd Hand Smoke Exposure Y N P

Gastrointestinal
 Bowel Movements _____ x/day Color _____ Consistency _____
 Blood in stool Y N P Constipation Y N P
 Vomiting Y N P Diarrhea Y N P
 Gas/bloating Y N P Change in appetite Y N P
 Hernia Y N P Abdominal pain Y N P
 Heartburn Y N P Weight loss Y N P

Urinary
 Age of Toilet Training _____ Bedwetting Y N P
 Increase frequency Y N P Pain with urination Y N P
 Infections Y N P Urethral Discharge Y N P

Males

Inguinal hernia	Y	N	P	Undescended testicle	Y	N	P
Testicular self exams	Y	N					
Onset of puberty	Y	N	Age _____	Changes in body	_____		
Sexually active	Y	N	Birth control use	Y	N	Type	_____

Females

Inguinal hernia	Y	N	P	Vaginal discharge	Y	N	P
Onset of menstrual cycle	Y	N	Age _____	Sexually active	Y	N	
Onset of puberty	Y	N	Age _____	Changes in body	_____		
Birth control use	Y	N	Type	_____			

Musculoskeletal

Fractures	Y	N	P	Muscle weakness/pain	Y	N	P
Joint pain	Y	N	P	Joint swelling	Y	N	P

Neurological

Tremors	Y	N	P	Seizures	Y	N	P
Paralysis	Y	N	P	Delayed Development	Y	N	P

Endocrine

Excessive hunger	Y	N	P	Excessive thirst	Y	N	P
Excessive fatigue	Y	N	P	Difficulty sleeping	Y	N	P

Mental & Emotional Health

Fears	Y	N	_____				
Excessive anger	Y	N	_____				
Mood swings	Y	N	_____				
Separation anxiety	Y	N	_____				
Depression	Y	N	_____				
Issues around body image	Y	N	_____				
Other issues	_____						

Socialization, Personality, & Home life

Sleeping patterns _____

Interaction with other kids: Leader or follower? _____

Siblings	Y	N	Ages & gender	_____			
Watches TV	Y	N	Hours daily	Video Games	Y	N	Hours daily _____
Reading?	Y	N	Hours daily	_____			
Learning problems	Y	N	_____				
Problems with social interactions?	_____						

Activities

Sports	Y	N	Which ones	_____			
Social, school or church organizations	Y	N	Which ones	_____			
Part-time job	Y	N	Hours/week	_____			

Thank you for taking the time to fill out this form completely. During your office visit, we will discuss some of your responses in detail. Please feel free to attach any additional sheets describing your medical history or symptoms in detail.

Consent to Naturopathic Treatment Provided by Breana Hauskins-McElgunn, ND

- I. This is to acknowledge that I have been informed and understand that:
- i) Any treatment or advice provided to me as a patient of Breana Hauskins-McElgunn, ND is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.
 - ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider
 - iii) I understand that Breana Hauskins-McElgunn, ND is not preventing me from seeking or following the advice of another licensed health care provider.

- iv) The treatment and therapies provided to me by Breana Hauskins-McElgunn, ND may be different from those offered by another licensed health care provider.
- II. I agree to pay for any fees for services, costs of supplements and homeopathic remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan, at the time of the visit.
- III. I hereby authorize and consent to treatment.

Signature Parent/Guardian

Date

Gallatin Valley Natural Medicine

2002 North 22nd Ave. Suite 2
Phone: (406) 587-0858

Bozeman, MT 59718
Fax: (406) 586-0406

Dr. Breana McElgunn, Naturopathic Physician

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO HIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the Gallatin Valley Natural Medicine Clinic.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires our specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information

- The right to receive confidential communications concerning your medical condition and treatment

- The right to inspect and copy your protected health information

- The right to amend or submit corrections to your protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed

- The right to receive a printed copy of this notice

GVNM Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing.

You may obtain a form to request access to your records from Gallatin Valley Natural Medicine at the above address. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Further Information

If you would like to submit a comment or complaint about our privacy practices, or if you need any further information concerning privacy practices please contact Gallatin Valley Natural Medicine at the above address. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to this address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This notice is effective on or after 04/16/2003

I have read and understand the Privacy Practices For Protected Health Information.

Signature

Date

Print Name _____