Dr. Breana McElgunn, ND
Naturopathic Physician
406-587-0858 Office
406-414-0213 Fax

Gallatin Valley Natural Medicine
P.O. Box 4011
Bozeman, MT 59772-4011

Pediatric Patient Intake (6 - 15 yrs)

Please complete this confidential intake form.

Name _____ Parent(s) Name _____ Birth Date _____
Address _____ City & State _____ Zip _____
Social Security # _____ Home Phone _____ Emergency 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, please list:_____
_____
_____

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
Stuffiness	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 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 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 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 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

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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 you 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 (parent or Guardian) Date

Print Name _____