Carolina Partners Wellness Center

DR. PARKES
NEW PEDIATRIC PATIENT INTAKE FORM

Instructions: Please complete this form, save it and return it via email to: info@drparkes.com before your scheduled appointment, fax it to: 919-792-3949, or mail it to: Carolina Partners Wellness Center 1011 Dresser Ct. Raleigh, NC 27609.

Dr. Kivette Parkes ND
Doctor of Naturopathic Medicine

Patient Introduction and Informed Consent

Naturopathic doctors obtain a doctorate in naturopathic medicine after graduating from an accredited naturopathic medical institution. Naturopathic doctors complete training in the study of biological sciences and conventional medical diagnosis and treatment. In addition, naturopathic doctors receive extensive training in clinical nutrition, homeopathy, botanical medicine, physical medicine and counseling. Naturopathic doctors concentrate on whole-patient wellness. Recommendations are specific to each patient and emphasize prevention and self-care. Naturopathic doctors focus on the underlying cause of the patient's condition rather than focusing solely on symptoms. Naturopathic therapies may require more time to be effective, yet often provide long-lasting health improvements.

A Naturopathic Doctor (ND) is trained as a primary care provider and is a board-certified physician in states where licensure is applicable. Currently licensure for naturopathic doctors is not available in North Carolina. Therefore, Dr. Parkes does not practice medicine, and does not provide diagnosis or treatment of any particular diseases or medical conditions in the state of North Carolina. Dr. Parkes is registered as a professional Naturopath in the state of North Carolina (License NO: 20001913134) and focuses her practice on the enhancement of health. She treats people, not symptoms or diseases and works with each patient to help them realize a greater state of overall health. In the state of North Carolina, Dr. Parkes is a specialist in natural medicine, not a primary care physician, therefore all patients are advised to maintain a relationship with their primary care doctor.

All therapies, including the naturopathic modalities have the potential to create both desirable and undesirable effects. Of the latter, such effects can include the following: allergic reactions/sensitivities/adverse effects to recommendations of natural supplements and lifestyle modifications.

With this knowledge, I voluntarily consent to allow Dr. Parkes to advise me based on her expertise. I realize that no guarantees have been given to me by Dr. Parkes, regarding cure or improvement of my condition. I understand that I am free to withdraw this consent and discontinue participation at anytime. I also understand that my participation in my own health is essential for a good outcome and that I am personally responsible for following all the recommendations to the best to my abilities (eg. diet, exercise, supplements …).

Date:

Responsible Party Name: Relationship to Child:

Initials:

Dr. Kivette Parkes ND
Doctor of Naturopathic Medicine

Release of Information

All information provided herein is true and correct. I hereby consent to being advised by Dr. Parkes. I give permission to my provider Dr. Parkes and staff to release information, verbal and written, contained in my medical record and other related information to related health care providers, assignees and/or beneficiaries and other related persons. I have read and understood this release.

Initials: Date:

Payment Policy

All services provided by Dr. Parkes must be paid for before the date of service. All patients are required to keep a credit/debit card on file. When you schedule an appointment, Dr. Parkes reserves that time exclusively for you. Therefore, service fees are non-refundable. In order for your appointment to be confirmed your card will be debited 2 business days before your visit, unless other arrangements are made or your visit has been pre-paid.

Patients participating in the 'Not Just Weight' weight management program and the Nutrition Response program will have their monthly program fees automatically debited once per month unless the fees have been pre-paid.

You may pre-pay your visit using another form of payment in person or by phone at least 2 business days before the scheduled visit.

Supplements and other items are available in the office for purchase and can be paid for at the time of purchase.

For special order drop-ship supplements: When payment is received, your order will be shipped directly to the address provided.

Initials: Date:

Appointment Cancellation Policy

48 hours notice is required when canceling/rescheduling an appointment. Any in person appointment may be rescheduled as a phone appointment to avoid cancellation. In emergency cases, your appointment will be rescheduled for the next available date with less then 48 hrs notice. No credit will be given for missed appointments.

Initials: Date:

By completing and submitting this form you acknowledge that you have read and understood the above statements.

NEW PATIENT INFORMATION

Date:

Child's name:

Age:

Date of birth:

Child's grade level:

Sex (circle): M F

Who is filling out this form? (name and relationship):

How did you learn about this practice?

Who does the child live with?

Guardian Contact Information:

Name and relation to child:
Address:
Phone number: (home) (alternate)

Name and relation to child:
Name and relation to child:
Address:
Phone number: (home) (alternate)

Please list child's **current health care providers** with their **designation** (pediatrician, family physician etc.) and **contact information**:

Does your child have any known contagious diseases at this time? No Yes
If yes, explain:

Does your child have any known life-threatening allergies? No Yes
If yes, explain:

Pediatric Health Overview – *Comprehensive health care requires a complete picture of health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

PRIMARY HEALTH CONCERNS

What is your child's blood type?

In your opinion, what are your child's most important health concerns?
1.
2.
3.
4.
5.

Can you identify any events (life trauma, surgery, drug reactions) as having caused or aggravated your child's health concerns?

MEDICAL HISTORY
How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

Current medications or supplements and why they are being taken.
Medications:

1.
2.
3.
4.
5.

Supplements

1.
2.
3.
4.
5.

List any past medications or supplements:

How many times has your child had antibiotics?

Does your child have any allergies (food, medications, environmental)?

Has your child been to see the dentist? [ ] yes [ ] no
Describe any dental work done:

Describe your child's daily oral hygiene practice:

Has your child had their vision checked?
[ ] yes [ ] no Describe any vision problems:

Digestive and Urinary Health

Frequency of bowel movements:

Does your child experience any pain when passing stool?

Do any of your child's bowel habits concern you?

Are there any urinary symptoms you are concerned about?

General Health

Has your child ever experienced any of the following conditions?
If you are unsure of any of the terminology please put a question mark beside the word.

Allergies- seasonal[ ] yes [ ] no
Diarrhea [ ] yes [ ] no
Allergies-environmental [ ] yes [ ] no
Difficulty concentrating [ ] yes [ ] no
Measles [ ] yes [ ] no
Cold sores [ ] yes [ ] no
Meningitis [ ] yes [ ] no
Colic [ ] yes [ ] no
Mumps [ ] yes [ ] no
Conjunctivitis (pink eye) [ ] yes [ ] no
Pneumonia [ ] yes [ ] no
Constipation [ ] yes [ ] no
Sinusitis [ ] yes [ ] no
Convulsions [ ] yes [ ] no
Skin rash [ ] yes [ ] no
Cradle Cap [ ] yes [ ] no
Strep throat [ ] yes [ ] no
Croup Thrush Diabetes

Tonsilitis [ ] yes [ ] no
Diaper rash [ ] yes [ ] no
Urinary tract infection [ ] yes [ ] no
Seizures [ ] yes [ ] no
Headaches [ ] yes [ ] no
Appendicitis [ ] yes [ ] no
Difficulty sleeping [ ] yes [ ] no
Atopic Dermatitis [ ] yes [ ] no
Ear infection [ ] yes [ ] no
Asthma [ ] yes [ ] no
Eczema [ ] yes [ ] no
Bronchitis [ ] yes [ ] no
Frequent colds [ ] yes [ ] no
Cancer [ ] yes [ ] no
Hay fever [ ] yes [ ] no
Chicken pox [ ] yes [ ] no
Head lice [ ] yes [ ] no
Chronic Bedwetting [ ] yes [ ] no
Hyperactivity [ ] yes [ ] no
Chronic nose bleeds [ ] yes [ ] no
Impetigo [ ] yes [ ] no
Chronic Bruising [ ] yes [ ] no

VACCINATION HISTORY

Has your child been vaccinated?
If yes, indicate which vaccines.
[ ]Hepatitis B []DPT or DT– (Diptheria,Pertussis, Tetanus) [ ] Polio
[ ] Hemophilus B []MMR–(Measles,Mumps, Rubella) [ ]Tetanus
[ ] Chicken pox []Flu [ ] Other:
Has your child experienced any adverse reactions from a vaccination: No Yes
If yes, explain:

FAMILY HISTORY

Have any close relatives had any of the following conditions:

[ ] Allergies
[ ] Seizures
[ ] Anemia
[ ] Stroke
[ ] Asthma
[ ] Kidney disease
[ ] Birth defects
[ ] Psoriasis
[ ] Diabetes
[ ] Bleeding disorder
[ ] Depression
[ ] Cancer

[ ] Eczema
[ ] Mental illness
[ ] High blood pressure
[ ] Glaucoma
[ ] Juvenile Arthritis
[ ] Hay fever
Do either of the parents have any history of chronic illness?

LIFESTYLE

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

Does your child take naps? If yes, when?

Do they have any trouble falling asleep?

Do they sleep straight through the night?

Do they wake up looking/acting refreshed?

Do they have any recurring dreams or nightmares?

Please write a short description of your child as he/she is currently. Include strengths, weaknesses and major personality traits: (You may skip the following section for infants)

Is your child currently in school, daycare, at home?

How would you describe your child's behavior in school/ daycare?

Does this differ greatly from behavior at home?

What makes your child angry?

Do they have any difficulties expressing anger? Do they experience uncontrollable rage? What makes your child sad?

Does he/she cry when sad?

List any major experiences of grief or loss in your child's life.

What fears does your child have?

How does your child react when afraid?

What activities does your child enjoy the most?

What is the emotional climate in the child's home?

Does anyone in the household smoke?

Does the child exercise regularly?

How much and what form of activity?

How many hours of television does your child watch each day?

PRE-NATAL HEALTH AND BIRTH HISTORY

How old was the mother at the time of the child's birth?

Number of previous pregnancies the mother carried to term?

Did the mother receive medical care during pregnancy?

Did the mother use any of the following during her pregnancy?
_____alcohol
_____cigarettes
_____recreational drugs
_____prescription drugs
_____over the counter medications (eg.Tylenol)
_____supplements or remedies?
_____unknown

How was the health of the mother at time of conception?

How was the health of the father at time of conception?

How was the health of the mother during the pregnancy?

How was the emotional state of the mother during pregnancy?

How was the mother's diet during pregnancy?

Were there any interventions used during the pregnancy? (eg. ultrasound or amniocentesis)
Were there any interventions used or complications during the delivery? (eg. epidural, forceps, c-section, induction)

Weight of infant at birth:
Term length of pregnancy: [ ] pre-term (37 weeks or less): _____ weeks
[ ] full-term (38-42 weeks): _____ weeks
[ ] post-term (42 weeks or more): _____ weeks

Did the infant experience any of the following conditions during or following the birth? (If yes, explain)
[ ] injuries during the birth:
[ ] birth defects:
[ ] jaundice:
[ ] infections:

DIET HISTORY

Breast fed?
How long?
Formula?
How long?
What type of formula was used? (milk, soy, other)
At what age was solid food first introduced?

Did your child have any reaction to the food being introduced?

Does your child have any known food allergies?

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan)

What is a typical day's diet for your child?
Breakfast:
Lunch:
Dinner:
Snacks:
Beverages:

List any foods that your child seems to crave:

Is your child thirsty? [ ] yes [ ] no

Amount of liquid child drinks each day?
Amount of Plain water:

What temperature of liquid does your child prefer to drink?

What is the approximate weight of your child?

Has there been any recent weight gain or weight loss?

Are you satisfied with your child's diet the way that it is now?

Why or why not?

Is there anything else you would like to comment on?

Thank you for taking the time to fill in this information.