

GIG HARBOR NATUROPATHIC MEDICINE, PS
DR. LESLIE CHARLES, ND

ADD/ADHD/AUTISM SPECTRUM INTAKE FORM

NAME _____ SEX _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (MOM CELL) _____ (DAD CELL) _____

MAY WE LEAVE A HEALTH-RELATED MESSAGE ON THE HOME PHONE? YES NO CELL? YES NO

BIRTHDATE ___/___/___ AGE ___ BIRTH HEIGHT/WEIGHT: _____ NO. OF SIBLINGS: _____

LIVES WITH: BOTH PARENTS MOM DAD GRANDPARENTS FOSTER FAMILY OTHER

DATE OF LAST PHYSICAL EXAM? _____ WHERE? _____

NAME IN CASE OF EMERGENCY _____ PHONE _____

WHAT OTHER HEALTH CARE ARE YOU PRESENTLY RECEIVING? _____

NAME OF PEDIATRICIAN: _____

WHERE DID YOU HEAR ABOUT OUR CLINIC? _____

PRESENT HEALTH CONCERNS: IN YOUR OPINION, WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS IN THEIR ORDER OF SIGNIFICANCE? PLEASE INDICATE THE PROBLEM THAT MOTIVATED YOU TO COME IN TODAY.

1. _____ 4. _____
2. _____ 5. _____

MEDICATIONS: SUPPLEMENTS, PRESCRIPTION & NON-PRESCRIPTION DRUGS.

1. _____ 5. _____
2. _____ 6. _____

INSURANCE INFORMATION:

INSURANCE COMPANY _____

ID # _____ GROUP# _____

INSURED NAME _____ RELATIONSHIP _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT DR. CHARLES WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME THAT MY INSURANCE CARRIER DOES NOT COVER I AM PERSONALLY RESPONSIBLE TO PAY. I FURTHER AGREE TO A FINANCE CHARGE OF 1% MONTHLY ON ALL PAST DUE ACCOUNTS. PAYMENT IS EXPECTED AT TIME OF VISIT.

PATIENT SIGNATURE _____ DATE ___/___/___

PARENT OR GUARDIAN SIGNATURE _____

YOUR HEALTH HISTORY

MOM'S PREGNANCY: GOOD FAIR POOR MOM'S WEIGHT GAIN IN PREGNANCY: _____LBS.

MEDICATIONS/ILLNESSES/COMPLICATIONS IN PREGNANCY: _____

BIRTH: HOSPITAL/BIRTH CENTER/HOME VAGINAL/C-SECTION PITOCIN/PAIN MEDS/ANTIBIOTICS

WERE YOU BREASTFED? YES NO FOR HOW LONG? ____MOS. FORMULA INTRODUCED AT _____

HOSPITALIZATIONS (YEAR & REASON) _____

SERIOUS ILLNESSES OR INJURY (YEAR & CAUSE) _____

VACCINATIONS: UP-TO-DATE PARTIAL ADVERSE REACTION

ALLERGIES: LIST ANY ALLERGIES YOU HAVE TO FOODS/DRUGS/ENVIRONMENTALS AND TYPE OF REACTION:

1. _____
2. _____
3. _____

HABITS:

DIET: WHAT DID YOU EAT YESTERDAY? PLEASE PROVIDE A SAMPLE OF YOUR DAILY DIET:

BREAKFAST: _____

LUNCH/SNACKS: _____

DINNER/DESSERT: _____

HOW IS YOUR SLEEP? _____ AVERAGE HRS OF SLEEP/DAY: _____

WHAT TYPE OF PHYSICAL ACTIVITY DO YOU GET? _____

FAMILY MEDICAL HISTORY

PLEASE LIST ANY PERTINENT HEALTH HISTORY FOR YOUR FAMILY: ECZEMA, ASTHMA, HEART DISEASE, CANCER, DIABETES, ANXIETY, DEPRESSION, MENTAL HEALTH ISSUES, LEARNING DISABILITIES, AUTOIMMUNE DISEASES, DIGESTIVE ISSUES, PSORIASIS, PARKINSONS, EPILEPSY, FIBROMYALGIA, OSTEOARTHRITIS, ETC.

MOM: _____

MATERNAL GMA: _____

MATERNAL GPA: _____

DAD: _____

PATERNAL GPA: _____

PATERNAL GMA: _____

BROTHER(S): _____

SISTER(S): _____

AUNTS/UNCLES: _____

Mother's Pregnancy

Before or During Pregnancy, did mom have any:

	Yes/No	Comments:
Trouble getting pregnant?		
Any fertility treatments?		
Have any dental work?		
Have a yeast infection?		
What is mom's blood type?		

Please describe any important information about the pregnancy including any health issues, fevers, medications taken, exposures (new home, painting indoors, insect extermination, etc), more than average ultrasounds, stress levels, etc:

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Your Birth!

Please answer the following questions about the birth itself:

	Yes/No	Comments:
Any antibiotics at birth?		
Pitocin used?		
Pain medication?		
Forceps used?		
Vacuum used?		
C-section or vaginal birth?		

Birth Weight and Apgar

Weight at birth: _____ lbs Apgar score at one minute _____ Apgar score at 5 mins _____
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Please describe how the birth went and any complications that occurred during or after the birth:

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Family Life Tell me about your family. Who do you live with and what are their professions and hobbies? Please include parents, siblings and pets (and everyone else under the same roof). Include ages of parents and ethnicity.

Who are the main people who care for you?

Providers and Therapy:

What specialists have you seen and for what? Are you currently under their care now?

Dr. _____

Dr. _____

Dr. _____

Who else are you seeing? How has this therapy been helpful for you?

OT: _____

PT: _____

ST: _____

Dentist and Last Exam Date: _____

Other: _____

Any other therapies or treatments you have tried are currently trying that I should know about?

Testing: Please provide at what age, where and results:

Hearing: _____

Vision: _____

Psychological Testing: _____

Speech and Language Evaluation: _____

Genetic Testing: _____