



Holistic, Anthroposophic & Traditional Pediatrics

Dear Patient of Center for Living Health,

Welcome to Center of Living Health, Inc. We look forward to having you as a patient and supporting you in a more balanced approach to health.

Enclosed is a copy of our new patient questionnaire. It can take awhile to fill out form completely; and we have found that a detailed patient history is one of the most effective ways of discovering the root cause of troublesome symptoms. Please be sure to complete this form ahead of time and bring it to your visit.

As you are aware, we are an out of Network provider, which means we do not participate with any insurance company. All patients are to pay at time of service for their care. We will provide you with a form to submit to your insurance company. Please refer to our web site for ideas on lowering costs with insurance. We are not responsible for any claims that are unpaid or rejected

We are located in Gold River at 11344 Coloma Road, Suite 445 in the Regent Park business complex (off of Sunrise Blvd near Hwy 50). You may want to plan on arriving early to account for difficulty finding the office, traffic, and filling out any additional registration forms (see our website for directions).

Again, welcome to the Center for Living Health. We look forward to seeing you soon!

Sincerely,

Michael Allen MD and medical staff



## Office Policies

1. Michael Allen, MD is out of network provider who does not accept insurance. The fee for service is due at the time of each visit. Initial \_\_\_\_\_
2. I am aware that the medical work as practiced by Michael Allen, MD may extend beyond conventional medical treatment. It is with this information that I request the services as provided and prescribed by Michael Allen, MD. Initial \_\_\_\_\_
3. We recommend our patients maintain a primary care physician for vaccinations after hours call, emergency, and hospital admissions. Initial \_\_\_\_\_
4. Office hours are Monday thru Friday 8:45 – 4:30. Please note we are not available for calls or visits outside of normal business hours. We are not open on weekends or holidays. Initial \_\_\_\_\_
5. If you are unable to keep your appointment for any reason, we require that you call as soon as possible to reschedule your visit. 24 Hours notice is required for cancellation of appointments.

I also acknowledge and agree to pay 50% of the visit for no-show appointments and for cancellations made less than 24 hours in advance. Initial \_\_\_\_\_

6. Patients agree to pay \$25.00 fee for returned checks. Initial \_\_\_\_\_
7. Refills need to be written by the doctor during your office visit, not by phone or fax. We will make exceptions for some patients with a 48 hour notice. Initial \_\_\_\_\_
8. Phone consultations are available for established patients at the same rate as our in office visit fee's. Brief follow up calls by our providers are free unless they exceed ten minutes, at which time they will be billed as a phone consultation. Initial \_\_\_\_\_

WE APPRECIATE YOUR COOPERATION AND LOOK FORWARD TO SERVING YOUR HEALTH NEEDS.

I have read this entire form and fully understand it and agree to abide by its terms.

Patient's /Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Child's Name if Parent signing \_\_\_\_\_





## Pediatric Medical Questions

Name: \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

Child's present physical health

\_\_\_\_\_

Child's present emotional health/disposition

\_\_\_\_\_

**Please list the top five health concerns of the child:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Has the child been seen by any other health care professional for these issues? If yes please explain \_\_\_\_\_

\_\_\_\_\_

What lab work (blood, urine, parasite, other) has the child most recently done? \_\_\_\_\_

Please list any operations/hospitalizations and the year they took place \_\_\_\_\_

\_\_\_\_\_

Please list any ER visits \_\_\_\_\_

Has child taken Antibiotics in the past  No  Yes. If yes, why \_\_\_\_\_

List any physical trauma (broken bones, stitches, accidents) that have taken place and age of child at the time

\_\_\_\_\_

Please list any emotional trauma, stress or life changes that the child has experienced

\_\_\_\_\_

Please list all the medications the child is taking, either over the counter or prescription:

\_\_\_\_\_

Please list any vitamins, herbs, homeopathics, anthroposophical remedies or supplements the child is currently taking:

\_\_\_\_\_

Are there any known medical allergies? (medications, latex, etc..) \_\_\_\_\_

With whom does the child live? Please describe child's daily living arrangements:

\_\_\_\_\_

Brothers and Sisters (name, age) and describe relationship with siblings



Check if your child has had any of the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Breath-holding spells  | <input type="checkbox"/> Chicken pox      |
| <input type="checkbox"/> Colic or esophageal reflux   | <input type="checkbox"/> Dehydration      |
| <input type="checkbox"/> Ear Infections <input type="checkbox"/> many <input type="checkbox"/> rarely <input type="checkbox"/> none |   |
| <input type="checkbox"/> Encephalitis   | <input type="checkbox"/> Head injuries    |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Meningitis       |
| <input type="checkbox"/> Passing out (syncope)  | <input type="checkbox"/> Strep Infections |
| <input type="checkbox"/> Seizures <input type="checkbox"/> with fever <input type="checkbox"/> w/o fever                            |   |

### Family Medical History

Check if your child or family members (parents, siblings, grandparents, aunts, uncles) have had any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma/Wheezing            | <input type="checkbox"/> Allergies                                   |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Anxiety                                     |
| <input type="checkbox"/> Bruise easily              | <input type="checkbox"/> Sensory Integration Dysfunction             |
| <input type="checkbox"/> Constipation               | <input type="checkbox"/> Colic                                       |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Heart Disease                               |
| <input type="checkbox"/> Alcohol Addiction          | <input type="checkbox"/> Mental Illness                              |
| <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Eczema                                      |
| <input type="checkbox"/> Psoriasis                  | <input type="checkbox"/> High Blood Pressure                         |
| <input type="checkbox"/> Alzheimers                 | <input type="checkbox"/> High cholesterol                            |
| <input type="checkbox"/> Frequent ear infections    | <input type="checkbox"/> Heart murmur                                |
| <input type="checkbox"/> Frequent antibiotic use    | <input type="checkbox"/> Heart attack at < age 50                    |
| <input type="checkbox"/> Frequent Steroid use       | <input type="checkbox"/> High blood pressure                         |
| <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Croup <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High blood lead levels     | <input type="checkbox"/> Arthritis                                   |
| <input type="checkbox"/> Hay fever / allergies      | <input type="checkbox"/> Thyroid problems                            |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Diabetes                                    |
| <input type="checkbox"/> Head injuries              | <input type="checkbox"/> Kidney / bladder problems                   |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Sexually transmitted disease                |
| <input type="checkbox"/> Learning problems          | <input type="checkbox"/> Problems with bones                         |
| <input type="checkbox"/> Hyperactivity              | <input type="checkbox"/> Problems with muscles                       |
| <input type="checkbox"/> Developmental delay        | <input type="checkbox"/> Emotional disorders                         |
| <input type="checkbox"/> Autism                     | <input type="checkbox"/> Depression                                  |
| <input type="checkbox"/> Hearing problems           | <input type="checkbox"/> Bipolar disorder                            |
| <input type="checkbox"/> Dental problems            | <input type="checkbox"/> Other:                                      |
| <input type="checkbox"/> Skin problems / eczema     | <input type="checkbox"/> Alcohol / substance abuse                   |
| <input type="checkbox"/> Problems with digestion    | <input type="checkbox"/> Suicide                                     |
| <input type="checkbox"/> Gastric Reflux disease     | <input type="checkbox"/> Other Illnesses: _____                      |
| <input type="checkbox"/> Cancer: Type: _____        | <input type="checkbox"/> Other: _____                                |



**Birth History**

Lbs \_\_\_\_\_ Weeks \_\_\_\_\_

**Health of baby at birth** \_\_\_\_\_ **APGARS** (if known) \_\_\_\_\_

**Post Natal Complications**

- None  Jaundice  Respiratory  Cardiac  Infections  Gastrointestinal  Hospitalized -- How long? \_\_\_\_\_
- Cradle cap  Eczema  Colic  Constipation  Tight neck muscles (Torticollis)  Flattening of the skull

**Mother's age at delivery** \_\_\_\_\_ **Number of Pregnancies** \_\_\_\_\_ **Number of Live Births** \_\_\_\_\_

**Where is child in birth order (if other siblings)** \_\_\_\_\_

**Medications during Pregnancy**  None  Prenatal Vitamins  Other - Please name \_\_\_\_\_

**Mother's Pregnancy**

- Uncomplicated  Early Labor  Nausea and Vomiting  Bleeding  Diabetes  Thyroid Problems  Pre-eclampsia

Please describe Mother's Pregnancy (planned, problems, high risk, stressful, emotions, concerns, expectations)

\_\_\_\_\_

**What type of delivery did the mother have?**  vaginal  C-section  forceps **length of labor** \_\_\_\_\_

**Difficulties related to birth:**

\_\_\_\_\_

**Was the child conceived**  Naturally  Aid of In Vitro Reproduction Technology. What kind \_\_\_\_\_

**Check all that the mother experienced during pregnancy:**  Cigarette smoking  Lived with a smoker  Drank Alcohol  Recreational drugs  Prescription Drugs  Physical abuse  Emotional abuse

Has child had regression of speech  yes  no Difficulty comforting  yes  no Difficulty nursing  yes  no

**Was child breastfed** \_\_\_\_\_ **Until what age** \_\_\_\_\_

When was child put on formula \_\_\_\_\_ What kind \_\_\_\_\_

When was the child put on solid food \_\_\_\_\_ How did child do initially on solid food \_\_\_\_\_

**Developmental History**

How old was child when: Social Smile \_\_\_\_\_ Tracking \_\_\_\_\_ Rolled over \_\_\_\_\_

Sat \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_ Talked \_\_\_\_\_ Toilet trained \_\_\_\_\_

Slept through night \_\_\_\_\_

Does child bedwet?  no  yes (if yes, is there history of any bedwetters in family) \_\_\_\_\_



### Vaccination History:

Please check if child had the vaccination or not, check some if child had vaccination but did not finish all the shots. List any reactions.

MMR  Yes  No  Some Reaction \_\_\_\_\_

DTaP  Yes  No  Some Reaction \_\_\_\_\_

Hep B  Yes  No  Some Reaction \_\_\_\_\_

Hib  Yes  No  Some Reaction \_\_\_\_\_

Polio  Yes  No  Some Reaction \_\_\_\_\_

Chicken Pox  Yes  No  Some Reaction \_\_\_\_\_

Pneumococcal  Yes  No  Some Reaction \_\_\_\_\_

Influenza  Yes  No  Some Reaction \_\_\_\_\_

Hepatitis A  Yes  No  Some Reaction \_\_\_\_\_

Rotavirus  Yes  No  Some Reaction \_\_\_\_\_

Meningococcal  Yes  No  Some Reaction \_\_\_\_\_

HPV  Yes  No  Some Reaction \_\_\_\_\_

Other \_\_\_\_\_  Some Reaction \_\_\_\_\_

Please list known allergies to food, drugs, environment or animals

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Has the child ever lived:  near a Refinery, high voltage power lines, or other highly polluted area  in a house with lead based paint  
 in a house with new paint, cabinets or carpet that seemed to affect child  
 in a household that had mold in walls  in a house with smokers

Are pesticides, herbicides or toxic cleaners used in the house where child lives?  yes  no

### HOME AND FAMILY

How much TV or computer time does the child spend each week? \_\_\_\_\_ average daily hours \_\_\_\_\_ average weekend hours

Does the child engage in physical exercise?  no  yes, (what kind) \_\_\_\_\_

Does the child participate in any after school activities \_\_\_\_\_

Child's special interests or talents \_\_\_\_\_

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What are your child's gifts? (what comes easily to them)

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What are your child's challenges (things that are difficult)

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What does your child want to be when he/she is older?

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Does child have any pets  no  yes If yes, what kind \_\_\_\_\_



Describe child's typical diet (favorite foods, snacks, meals)

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Snack \_\_\_\_\_

Dinner \_\_\_\_\_

How much water does child drink on daily basis \_\_\_\_\_

Does child drink soft drinks/soda, if yes, how much \_\_\_\_\_

### BEHAVIOR

Is there a history of  biting  hitting  head banging  aggressiveness  odd fascinations  bed wetting  stuttering  
 teeth grinding at night  teeth grinding in day  pulling own hair

How does child interact with other children \_\_\_\_\_

Child's bedtime \_\_\_\_\_ Time child awakens \_\_\_\_\_ Describe how child awakens (dreamy, cheery, crabby, etc.) \_\_\_\_\_

Sleep Pattern  normal  difficulty falling asleep  frequent waking  nightmares  night terrors  other \_\_\_\_\_

Does your child snore while sleeping?  no  yes

Does your child have pauses or stop breathing while sleeping?  no  yes

Describe any habits of child (thumbsucking, chewing/twisting hair, nail biting, etc) \_\_\_\_\_

Excessive fears of child or activities that make them anxious:  water  being alone  dark  night terrors  thunder  strangers

Please describe \_\_\_\_\_

Does child have any sensitivity to  sound  touch  smells  lights  other (please describe) \_\_\_\_\_

Abnormal movements  none  excessive turning  hand flapping  tics

***Thank You for taking the time to fill out this form so that we may better know you and your child. We look forward to supporting your family in a more balanced approach to health.***