



## A WELLSPRING OF NATURAL HEALTH, PC

Person-Centered Health Care • Natural Medicine for the Whole Family

### Pediatric New Patient - Intake Forms

☐ Mitchell Bebel Stargrove, ND, LAc.

☐ Lori Beth Stargrove, ND

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Birth time \_\_\_\_\_ a.m./p.m. Birth place \_\_\_\_\_

Age \_\_\_\_\_ Gender identity \_\_\_\_\_ Ethnic /Ancestral origins \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Work/Cell # \_\_\_\_\_

Child's Primary Guardian \_\_\_\_\_ Home phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Primary Contact Email Address \_\_\_\_\_

Who referred you to WellSpring? \_\_\_\_\_

Primary Medical Insurance Co. \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Secondary Medical Insurance \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Telephone # \_\_\_\_\_ Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

What is the name of the Doctor's Office/Hospital/Clinic where your child's medical records are kept?

Name \_\_\_\_\_

Address \_\_\_\_\_

Reason for referral or presenting problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Medical History

_____ Chicken pox	_____ Trauma	_____ Ear infections
_____ Measles	_____ Rheumatic fever	approx. # _____
_____ Mumps	_____ Frequent colds	_____ Tonsillitis
_____ Rubella	_____ Social difficulty	approx. # _____
_____ Scarlet fever	_____ Pneumonia	

Other (please list) \_\_\_\_\_

ABO blood type \_\_\_\_\_ FUT2 Secretor status \_\_\_\_\_ Vitality \_\_\_\_\_

Injuries/Surgeries/Hospitalizations (please list): \_\_\_\_\_

Has your child had any of the following tests or evaluations?

	When/Where	Findings
Electroencephalogram/EEG	_____	_____
Hearing	_____	_____
Speech/Language	_____	_____
ADD/ADHD	_____	_____
Psychological/Behavioral	_____	_____

## Medication History

Which of these substances has this child used or been prescribed?

Aspirin	Y N	Antidepressant	Y N	Reflux suppressants	Y N
Tylenol	Y N	Anxiety medication	Y N	Anti-histamines	Y N
Ibuprofen	Y N	ADD/ADHD Rx	Y N	Antibiotics	Y N
Steroid	Y N	Sleeping aid	Y N	Laxatives	Y N

Allergies/Reactions to Medications \_\_\_\_\_

## Immunizations

Diphtheria/Tetanus/Pertussis (DTaP)	Y N	Hepatitis A	Y N
Measles/Mumps/Rubella (MMR)	Y N	Hepatitis B	Y N
Chicken pox/Varicella	Y N	Human Papillomavirus (HPV)	Y N
Polio	Y N	Meningococcal	Y N
Flu/Influenza	Y N	Pneumococcal/Pneumonia	Y N
Tetanus (alone)	Y N	Other _____	

Adverse reactions? Y N When? What? \_\_\_\_\_



## Family History

☐ Check if adopted

	MOTHER			FATHER			
	<u>Mother</u>	<u>Grandmother</u>	<u>Grandfather</u>	<u>Father</u>	<u>Grandmother</u>	<u>Grandfather</u>	<u>Siblings</u>
Age (if living)	_____	_____	_____	_____	_____	_____	_____
Health (Robust, Compromised, Mixed)	_____	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____

Check (✓) those applicable

Cancer	_____	_____	_____	_____	_____	_____	_____
Diabetes /hypoglycemia	_____	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____	_____
Depression/anxiety	_____	_____	_____	_____	_____	_____	_____
Asthma/hayfever/hives	_____	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____	_____
Chemical/pesticide exposure	_____	_____	_____	_____	_____	_____	_____
Dysfunctional family	_____	_____	_____	_____	_____	_____	_____
Sexual abuse/rape	_____	_____	_____	_____	_____	_____	_____
Addiction/alcoholism	_____	_____	_____	_____	_____	_____	_____
Violence	_____	_____	_____	_____	_____	_____	_____
Food deprivation	_____	_____	_____	_____	_____	_____	_____
Poverty	_____	_____	_____	_____	_____	_____	_____
Immigration	_____	_____	_____	_____	_____	_____	_____
War	_____	_____	_____	_____	_____	_____	_____



## Prenatal History

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_

\_\_\_\_\_

Mother's relationship and family situation during pregnancy? \_\_\_\_\_

\_\_\_\_\_

Mother's health during pregnancy:

_____ Bleeding	_____ Diabetes	_____ Tobacco, alcohol, drug use
_____ Nausea/Vomiting	_____ Anemia	_____ Physical/emotional trauma
_____ Thyroid problems	_____ Pre-eclampsia	
_____ Hypertension	_____ Poor or compromised diet	

## Birth and Neonatal History

Mother's age at time of child's birth? \_\_\_\_\_ Term: Full \_\_\_\_\_ Premature \_\_\_\_\_ Late \_\_\_\_\_

Length of labor \_\_\_\_\_ Delivery: Vaginal \_\_\_\_\_ Caesarian \_\_\_\_\_

Complications \_\_\_\_\_

Weight at birth \_\_\_\_\_ Length at birth \_\_\_\_\_

## Infancy History

Has your child had any of the following problems?

_____ Jaundice	_____ Fever	_____ Developmental disabilities
_____ Colic	_____ Seizures	_____ Rashes
_____ Constipation	_____ Birth defects or injuries	_____ Allergies
_____ Diarrhea	_____ Cerebral Palsy	Other _____

Other (explain) \_\_\_\_\_

Child's sleep patterns (first year) \_\_\_\_\_

Food intolerances (if any) \_\_\_\_\_

Feeding: Breast-fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ Milk: Cow \_\_\_\_\_ Soy \_\_\_\_\_ Goat \_\_\_\_\_

Age began solid foods? \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_



## Symptoms and Diagnoses

**Y** = Current Condition

**P** = Previous Condition

**N** = Never

<input type="checkbox"/> Hives	<input type="checkbox"/> Night Urination	<input type="checkbox"/> Anxiety or nervousness
<input type="checkbox"/> Eczema	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Cries easily
<input type="checkbox"/> Rashes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Fearful
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Vomiting spells	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Acne	<input type="checkbox"/> Anemia	<input type="checkbox"/> Nightmares
<input type="checkbox"/> High fevers	<input type="checkbox"/> Stomach aches	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Chronic rash	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Body/breath odor
<input type="checkbox"/> Weight issues	<input type="checkbox"/> Constipation	<input type="checkbox"/> Motion/car sickness
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Gas	<input type="checkbox"/> Low appetite
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Excessive appetite
<input type="checkbox"/> Headaches	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Canker sores
<input type="checkbox"/> Flat feet	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Cough
<input type="checkbox"/> Joint pains	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Allergies

## Current Drugs, Medications, Nutrients, Herbs, Remedies

Please list *any and all* prescription drugs, over-the-counter medications, nutrients, herbs or other remedies you are *currently* taking.

Medicines (Drug, vitamin, nutrient, herb, etc.)	How much? How often?	Prescribed by?	Since when?	Take regularly? Y/N



## Typical Food Intake

Breakfast: \_\_\_\_\_

\_\_\_\_\_

Lunch: \_\_\_\_\_

\_\_\_\_\_

Dinner: \_\_\_\_\_

\_\_\_\_\_

Between Meals: \_\_\_\_\_

\_\_\_\_\_

Liquids: \_\_\_\_\_

Cravings: \_\_\_\_\_

## Habits, Daily Activities and Life Situation

Main interests and hobbies? \_\_\_\_\_

Please describe your child's typical daily activities: \_\_\_\_\_

\_\_\_\_\_

What is your child's relationship to family, friends and community? \_\_\_\_\_

\_\_\_\_\_

Does your child's family have a religious faith or spiritual practice? Y N If yes, what? \_\_\_\_\_

**Y** = Current Condition

**P** = Previous Condition

**N** = Never

Eat regular meals?	Y N	Read?	Y P N
Eat out often?	Y N	How many hours per day? _____	
Drink cola or other soft drinks?	Y N	Television?	Y P N
Eat sugar or sweets?	Y N	How many hours per day? _____	
Add salt to food?	Y N	Gaming or Computer use?	Y P N
Sleep well?	Y N	How many hours per day? _____	
Average 8-10 hrs. sleep?	Y N	Cell phone/Texting	Y P N
Awaken rested?	Y N	How many hours per day? _____	
Spend much time outside?	Y N	Tobacco exposure?	Y P N



**Welcome to WellSpring! We are here to serve you.**



## Directions to WellSpring ~ 4720 SW Watson Avenue, Beaverton

### From South I- 5 or Tigard:

Take Interstate-5 to Hwy 217. Follow Hwy 217 North heading toward Beaverton. Take the **Allen Street Exit**. Turn left at the first stoplight, which is Allen Street. Go forward to the **third stoplight**, which is **Hall Boulevard**. Turn right onto Hall going North. After the stoplight at 5th Avenue, turn **left onto Third Avenue**. Go forward just short of **two blocks**. Our parking lot and building are located on the **right-hand side**. The clinic is on the Northeast corner of 3rd and Watson at 4720 SW Watson Avenue.

### From Downtown Portland:

Take **Highway 26 West** to Highway 217 South. Follow Hwy 217 and take the **Beaverton-Canyon Road Exit** (Highways 8 and 10). Turn right at the **second stoplight**, which is **Beaverton-Hillsdale Highway**, and then becomes **Farmington Road** as you cross the railroad tracks. Go forward to the **fourth stoplight**, which is **Watson Avenue** (two blocks past Hall Blvd.). Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner, nearest you, of 3rd and Watson at 4720 SW Watson Avenue.

### From SW Portland:

Take **Beaverton-Hillsdale Highway** west. After you pass underneath **Hwy 217**, go straight up to the **fifth stoplight**, which is **Watson Avenue**. Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.

### From Hillsboro or Aloha:

Take **Farmington Road** to downtown Beaverton. Turn right onto **Watson Avenue**. (If you have come to Hall Boulevard, you have gone two blocks too far.) The clinic is located **three blocks down on the left-hand corner**. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.





## Communication Guidelines

These are some guidelines that can make our communication more effective:

1. When you call the office, leave a message with the receptionist including a detailed description of your concerns and/or questions and a few times during which you will be available to talk on the phone. This initial information will enable your clinician to make a preliminary determination about whether your needs can be adequately addressed on the phone or whether you need to make an in-person appointment or a telemedicine appointment.
2. If the doctor has not returned your call in what you feel is a reasonable amount of time, you may call again. Our ability to respond will be delayed in the event that you do not answer the phone when an attempt is made to call you. Our working together will best facilitate your needs being addressed in a timely manner.
3. Timing is important. If you or your child is sick, call early in the workday. Likewise, avoid waiting until late in the week to contact us with an acute need.
4. Accurately prescribing medication over the phone is inherently difficult and compromised. If your medical condition has changed significantly since a recent visit or a new condition has emerged we can only provide responsible, effective and ethical medical care by understanding the unique presentation of your symptoms and your experience of your condition. The person-centered health care offered at WellSpring is best delivered in person and we will work to accommodate your needs in a timely manner. Telephone, electronic or other indirect communication can not provide us with the opportunity to serve you as well as seeing you in person.
5. Children and illnesses do not always follow the rhythms of the clinic schedule. Your clinician is available in the beyond clinic hours if you feel that you have a medical condition requiring urgent decision-making and/or treatment; the WellSpring voicemail system (press #2) will contact your clinician and transmit the detailed message you leave. You will be called as soon as possible. In the event of a medical emergency, call 911 or go to the nearest urgent care facility or emergency room.
6. The WellSpring website provides a contact form for communicating with our staff and practitioners. These submissions will be reviewed and responded to but are not a timely or reliable means of communications with your clinician regarding your health care and medical treatment. In general, we at WellSpring prefer to communicate directly on the phone or in person and do not use electronic communications such as email or the WellSpring website for discussing your health care or medical treatment. Such forms of electronic messages are useful and appropriate for matters involving clinic hours and policies, insurance verification, and other matters of general business. The staff email ([care@wellspringofhealth.com](mailto:care@wellspringofhealth.com)) and WellSpring website contact forms are available to more appropriately serve these functions. The clinicians at WellSpring do not use email for discussing your case or receiving documents. Email and online form submissions do not meet the confidentiality and security standards required by HIPAA and other relevant regulations and thus are not appropriate for transmitting personal information such your birthdate, social security number, passwords, etc.

**Thank you!**

**The Clinicians and Staff of A WellSpring of Natural Health, PC**

