NEW PATIENT REGISTRATION-PEDIATRIC **Sean Ceaser, ND. Annie Coughlin, ND**

Name:_____ Date:_____

Address: _____
(Street) (City) (Prov./State) (Postal/Zip code)

Parent's Tel#: _____ Work:_____ Cell:_____

Age:_____ Sex: M / F **Date of Birth**:_____

Parent's name(s):_____ email: _____

Child's medical doctor:_____

Other health practitioners involved in care: _____

Emergency phone contact: _____ Phone #_____

Does the child you have private insurance that covers Naturopathic Medicine? Yes No
Insurance provider _____. Limit of coverage $_____

How did you hear about the clinic?_____

If online, please give how you specifically found the website: _____

INFORMED CONSENT FOR TREATMENT for Dr. Sean Ceaser, ND

TO THE PATIENT'S PARENTS: You have the right, as a parent, to be informed about your child's condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment.

If you refuse any specific procedure this will not affect your child from receiving other care or future treatments.

I voluntarily request Dr. Ceaser and/or Dr. Coughlin to examine and treat my child and their health conditions. I understand that the course of care therapy may include the use of multiple modalities of Naturopathic medicine including nutritional supplements, injection therapies, intravenous nutrients, chelation, ozone and other therapies offered by Dr. Ceaser and/or Dr. Coughlin I understand that my verbal consent to a specific treatment and my willing participation in my child receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to have my child receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time for my child. I understand that I have the right and the opportunity to ask questions about my child's condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that payment is due in full at the time of service.

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.

All information given now or at any point in the future is confidential. It is Naturopathic Physicians Group's policy to require a medical release form before releasing medical records to anyone other than the patient. I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

_____ _____

Patient's or Parent's Name Patient's or Parent's Signature

Date:

MEDICAL HISTORY QUESTIONNAIRE

Please list the reasons for this visit in order of importance & how long your child's had the problem:

1._____

2._____

3._____

Please indicate your expectations and what you hope to accomplish with your Naturopathic visit:

Please circle all that apply. Note beside the symptom if you need. If it is a past concern please indicate "P" beside the symptoms.

Fatigue	Cold hands/feet	Asthma
Weight gain/loss	Dizziness	Cough
Cancer: Type & stage:	Seizures Insomnia. sleeps _____	Digestive problems: Diarrhea/
Pain:	hours/night	Constipation
Stiffness	Numbness/tingling	Nausea/vomiting
Depression:	Weakness	Liver problems:
Anxiety	Skin problems:	Gallbladder problems:
Excessive anger	Headaches:	Urinary difficulties:
Excessive fears	Eye problems:	Bed wetting
Weeping	Ear problems:	Bladder/kidney infection
Irritability	Sinus problems:	Period begins every _____ days
ADD	Metal taste	PMS:
Developmental delays	Frequent sore throats	Testicular pain
Autism	Heat/cold intolerant	Frequent infections
Memory loss/foggy thinking	Allergies:	Frequent colds/flus
Behavioral problems	Difficulty breathing:	Diabetes
Restless legs	Wheezing	Other:

BIRTH & DEVELOPMENTAL HISTORY. Please list any unusual symptoms early in the child's life:

_____

MOTHER'S HEALTH DURING PREGNANCY.

Mother's age at child's birth _____ Previous pregnancies, miscarriages _____

Y N Cigarettes/ drugs How many/ day _____ Y N Alcohol. How much? ____ Y N High blood pressure

Y N Gestational diabetes Y N Thyroid Problems Other:

CHILD'S CURRENT MEDICATIONS.Include medications, chemo & cancer drugs, vitamins, supplements, herbs, OTC drugs.

Medicine:	Dose:	Began on:	Stopped on:
1.			
2.			
3.			
4.			

List more on back if needed

Allergies: **Hospitalizations (& year):**

Diseases in family history: **Reactions to vaccinations:**