

Child's Name: _____

New Pediatric Patient Information

Patient Name: _____ Gender: M or F DOB: _____

Mother's Name: _____ Father's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mother's Cell: _____ Father's Cell: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Patient's Primary Care Physician: _____ Phone: _____

Primary Care Physician's Address: _____

If known, name of preferred local compounding pharmacy: _____

Any known allergies to medications? If yes, please list and describe adverse reason: _____

Privacy Constraints: _____

No Constraints—Ok to send mail and/or leave messages on answering machine or voice mail?

Emergency Contact Name: _____

Relationship to Patient: _____ Phone number(s): _____

Address: _____

Insurance Information:

While we do not participate with insurance and fees are due in full at the time of your visit, we will provide a duplicate copy for your encounter form ready to send to your insurance.

Policy Holder's Name: _____ Relationship to patient: _____ DOB: _____

Insurance Company: _____ ID #: _____ Group # _____

Policy Holder's Employer: _____

Child's Name: _____



3700 52nd Street SE
Grand Rapids, MI 49512
616-656-3700

Pediatric Patient Consent Form

To Whom It May Concern:

We ask that both parents sign this document and return it to the Born Clinic. Your signatures will document your understanding and consent of the principles and practices of Born Preventive Health Care Clinic (Born Clinic).

In asking Born Clinic for help in optimizing the options for my child, _____ (*name*), I understand that my child's symptoms may relate to other underlying medical issues. Evaluation and treatment of these medical issues may impact behavior and cognition. These symptoms are indicated on the questionnaire and other documents introduced at the initial visit. I am not seeking a cure for a disease/condition such as Autism, ADHD, Allergies, Asthma and other related problems, but rather an approach focusing on my child as an individual and his/her potential medical problems.

I understand that no environmental cause has proven to be linked to Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) or related problems in children or adults. However, due to the possible causative links, I desire to have the biochemical, immunological, and toxicological aspects of my child's problems investigated and treated.

I desire that my child be evaluated with diagnostic steps aimed at some or all of the following factors:

- Necessary dietary changes
- Vitamin, mineral, amino acid supplementation
- Detoxification, immune, antimicrobial, and enzyme therapy
- Other necessary medications and adjunctive interventions

I understand that many elements of this approach may be described as unproven or off-label. I understand that many of the above factors may be considered unproven or experimental by third party payers.

My signature below confirms my consent to the diagnostic approach embodied in this document and acknowledges that I have had ample opportunity to voice concerns or ask questions. Any specific measures taken have been or will be carried out by me or under my supervision as a parent.

To the extent that some of the approaches embodied in this document have already been undertaken in my child's care, I acknowledge that my understanding of the approaches at the time of first considering each of these steps was essentially no different than at the time of signing this document. At no time in the course of my child's care did any of the practitioners at Born Clinic lack my complete informed consent.

(Parent)

(Date)

(Parent)

(Date)

Child's Name: _____

PRENATAL HISTORY

Maternal age at delivery: _____ years

Number of dental amalgams (mom) _____

Illnesses during pregnancy:

Vaccines during pregnancy:

Other complications during pregnancy:

Complications during labor and delivery:

Mode of delivery: C-section or vaginal (circle one) If C-section, explain why:

If vaginal delivery, did you have forceps/vacuum?

Medications(s) during labor and delivery?

Full term/premature? (Circle one)

How many weeks at delivery? _____ weeks

Complications after delivery?

Medications given to child during hospital stay?

Child's Name: _____

MEDICAL HISTORY

Major surgeries – Please describe and give dates:

SURGERY	DATE(S)	RESULTS

Major injuries – Please describe and give dates:

INJURY	DATE(S)	RESULTS

Illnesses – Please list appropriate dates and any complications

ILLNESS	DATE(S)	COMPLICATIONS
Ear infections:		
Sinus infections:		
Bronchitis:		
Pneumonia:		
Thrush:		
Chicken Pox:		
Seizures:		
Mono:		
Other (please list):		

Please describe your child's STOOL pattern (Examples: daily, foul, large, mush, etc.):

Child's Name: _____

DIETARY/NUTRITIONAL HISTORY

Breast fed? Yes/No (Circle one) If yes, for how long: _____

Bottle fed? Brand of formula? _____ Begun at what age? _____ For how long? _____

Foods? Begun at what age? _____ First foods: _____

Whole milk? Yes/No (Circle one) If yes, begun at what age? _____

Known allergies to food? (Please list): _____

Suspected sensitivities to foods: (Please list): _____

Food cravings? (Please list): _____

Foods my child eats: (Place in appropriate column)

Food	Daily	3-5 times per week	1-3 times per week	Never or almost never	Used to eat a lot but no longer does.
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2%					
1%					
Skim:					
Cheese:					
Ice cream:					
Salty foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					

Check the most appropriate description below of your child's diet:

___ Most baby foods

___ Mostly dairy

___ Mostly vegetarian

___ Mostly carbs

___ Other, describe:

Child's Name: _____

Is your child sensitive to or bothered by any of the following? Please check (v) where appropriate and list specific products, if possible:

- | | |
|---|--|
| <input type="checkbox"/> Perfume/Cosmetics? | <input type="checkbox"/> Mold? |
| <input type="checkbox"/> Cleaning products? | <input type="checkbox"/> Pollens/grasses? |
| <input type="checkbox"/> Soaps? | <input type="checkbox"/> Animals (dander)? |
| <input type="checkbox"/> Detergents? | <input type="checkbox"/> Gasoline? |
| <input type="checkbox"/> Dust? | <input type="checkbox"/> Paint? |
| <input type="checkbox"/> Other? | |

Please list known allergies:

Please list other occupational exposures in family members (for example: dental office, scientist, pharmacist, painter, building/construction, foundry worker):

DEVELOPMENTAL HISTORY

Please list age when following skills were mastered and any problems associated with these skills:

First words: (Age: _____)

Phrases or sentences: (Age: _____)

Pulling to stand: (Age: _____)

Walking: (Age: _____)

Sitting up: (Age: _____)

Crawling: (Age: _____)

Running: (Age: _____)

Walking up and down steps without help: (Age: _____)

Jumping: (Age: _____)

Learned to pedal: (Age: _____)

Rode 2-wheel bicycle: (Age: _____)

Put on clothing: (Age: _____)

Child's Name: _____

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

Others:

SOCIAL HISTORY

Who lives in the home with your child:

Are any children in your family adopted:

Pets in the house:

List the people most important in your child's life:

Recent changes, losses, births, deaths, divorce, remarriage or moves:

Child's response to these changes:

Recent travel:

Is your child involved in any sports, music or other activities? Please describe:

How does your child interact with other children?

- With adults?
- What makes your child happy?
- Sad?
- Angry?
- Stressed?
- Sleep patterns (past and present):

