Dr. Shalini Almeida, ND, BHMS
15160 NW Laidlaw Rd, Suite 250
Portland OR 97229

Dia Natural Health Care

Phone: (503)-660-3550
Fax: (503)-506-0528
www.DiaNaturalHealth.com

Pediatric Intake Packet (Birth to 5 years)

Welcome to Dia Natural Health Care, LLC. In order to provide your child with the best possible care, we ask you to complete this form in its entirety. You can mail (with sufficient time), fax, e-mail, or drop this form off at the clinic prior to your appointment so that Dr. Almeida can review your health history ahead of time. If not, you can bring it with you to your appointment.

Patient Information

Name: _____ **Date:** _____

Age: _____ **DOB:** _____ **Gender**: _____ **Ethnicity**: _____

Parent's names: _____

Address: _____

Telephone: (Home): _____ **(Parent's work):** _____ **(Cell):** _____

Preferred number for messages and appointment reminders? _____

Can the staff at Dia Natural Health Care identify themselves when leaving a message? _____

Is it okay to leave a message with detailed information? _____

How did you hear about this clinic? _____May we thank them for the referral? yes ____ no ___

Has any other family member been seen at this practice? _____

What do you know about Naturopathic medicine/Homeopathic medicine?

_____

_____

Reason for Today's Visit/ Chief Complaint:

_____

_____

What are your child's most important health concerns?

1) _____
2) _____
3) _____

What are your health goals for your child? Please list.

1._____
2._____
3._____

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Does your child have any known contagious diseases at this time? Y / N

If yes, what? _____

Has your child been exposed to second hand smoke? Y / N For how long? _____

Prenatal History

Mother's age at child's birth? _____

Previous pregnancies by natural mother, miscarriages, or complications?_____

_____

_____

Mother's health during pregnancy:

_____ Bleeding _____ Physical or emotional trauma _____ Nausea

_____ Illnesses _____ Medications _____ Hypertension

_____ Thyroid problems _____ Cigarettes, alcohol, drug consumption _____ Diabetes

Birth History

Pregnancy term: _____ Full _____ Premature _____ Late

Child's weight at birth: _____

Labor/delivery complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby

_____ Cerebral palsy _____ Seizures _____ Jaundice

_____ Colic _____Fever _____ Rashes

Other:_____

Child's sleep patterns (1st year): _____

Food intolerances (if any): _____

Feeding: Breast fed? Y / N How long? _____ Formula? Y / N Type (milk/soy): _____

Age began solids: _____ Which foods? _____

Age began (if applicable): Sitting _____ Crawling _____ Walking _____ Talking _____

Immunizations *Check the applicable boxes. Dates of most current vaccine shot/booster will help.*

- ☐ DPT ___/___/____
- ☐ Tetanus ___/___/___
- ☐ Hep B ___/___/____
- ☐ MMR ___/___/____
- ☐ Other Vaccines ____
- ☐ Polio drops___/___/____
- ☐ Influenza ___/___/____
- ☐ Hep A___/___/____
- ☐ Pneumococcal ___/__/__
- ☐ Diptheria __/___/__
- ☐ Hib ___/___/_____
- ☐ Pertusis ___/___/___
- ☐ Chicken Pox__/__/_

Did your child have any adverse reactions? Y/ N If yes, please explain? _____

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Personal Medical History: *Check the applicable boxes, when necessary please explain:*

☐ Measles	☐ Asthma	☐ Tuberculosis
☐ Mumps	☐ Eczema	☐ Liver problems
☐ Rubella	☐ Psoriasis	☐ Gallbladder disease
☐ Chicken Pox	☐ Heart problems	☐ Kidney problems
☐ Whooping cough	☐ High blood pressure	☐ Headaches
☐ Rheumatic Fever	☐ Diabetes	☐ Mood problems
☐ Pneumonia	☐ Skin disorders	☐ _____
☐ Recurrent colds/flu	☐ Other Skin Disorders	☐ _____

Allergies

Is your child hypersensitive or allergic to….

Any drugs? _____

Any foods? _____

Environmental allergens/chemicals? _____

Has your child had any of the following tests? Indicate when and where and results.

Electroencephalogram (EEG): _____

Psychological evaluation: _____

Hearing tests: _____

Speech/language tests: _____

Any Injuries or Traumas (*ex: car accidents)?* _____

Any Surgeries or Hospitalizations?_____

Any Medical Imaging? (*If yes, indicate year)* ☐Xray ☐MRI ☐ CAT scan ☐EKG ☐EEG

_____

Family Medical History: *Check the applicable boxes, when necessary please explain*

☐ Birth Defects	☐ Diabetes	☐ Allergies
☐ Heart Disease	☐ Cancer	☐ Arthritis
☐ High blood pressure	☐ Tuberculosis	☐ Autoimmune disease
☐ Psoriasis	☐ Eczema	☐ _____
☐ Mental Illness	☐ Other Cancer ____	☐ _____

Diet

Does your child follow a specific diet? Please explain:_____

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

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Medications

Please list any prescription medications, over the counter medications, vitamins, or other supplements your child is currently taking or uses frequently. Include dosages.

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Habits

Does your child watch TV? Y/ N Approx. no. of hours/day: _____

Read? Y/ N Approx. no. of hours/day: _____

Spend time outside daily? Y/ N: Approx. no. of hours/day: _____

Eat refined sugar? Y/ N How much in a day: _____

Drink soda? Y/ N How much in a day: _____

CHILD LEAD RISK QUESTIONNAIRE

Did your child have an elevated blood lead level in the past? □Yes □No

Does your child have a sibling or playmate with lead poisoning? □Yes □No

Does your child live in or regularly visit a place built before 1978? □Yes □No

Is it being or was it recently remodeled or renovated? □Yes □No

Does anyone who spends time with the child have a job or hobby in:

- Automotive repair / car batteries □Yes □No
- Making ceramics or pottery using lead glaze □Yes □No
- Fishing sinkers / fishing activities / boat repair □Yes □No
- Painting / electrical / plumbing / soldering / welding □Yes □No
- Remodeling / renovation / building demolition □Yes □No

Does your child often eat, chew, or mouth dirt, paint chips, or other things that are not food? □Yes □No

Does the family cook or serve food using ceramic dishes or pottery that may have lead glaze (such as Chinese or Mexican pottery)? □Yes □No

Does the family have a catchment water system? □Yes □No

Review of Systems (Mark Y if current, P for past symptoms, leave blank if never)

_____ Hives	_____ Dizzy spells	_____ Bleeding gums
_____ Allergies	_____ Hair loss	_____ Canker sores
_____ Eczema	_____ Hearing loss	_____ Dental caries
_____ Chronic rash	_____ Vision problems	_____ Sore throats
_____ Acne	_____ Nose bleeds	_____ Wheezing
_____ Headaches	_____ Frequent colds	_____ Asthma

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_____ Cough
_____ Breath/body odor
_____ Sensitive to light
_____ Nervous
_____ Cries easily
_____ Sleep problems
_____ Nightmares
_____ Unusual fears
_____ Heart murmur
_____ No appetite
_____ Jaundice
_____Stomach aches
_____ Motion/car sickness
_____ Bloating/Gas
_____ Constipation
_____ Diarrhea
_____ Vomiting spells
_____ Frequent urination
_____ Bloody urine
_____ Burning of urine
_____ Bleeding tendency
_____ Easy bruising
_____ Anemia
_____High fevers
_____ Night sweats
_____ Excessive fatigue
_____ Flat feet
_____ Joint pains

Any other information about your child's health that you would like to add?_____

Recent Medical Care: *Write N/A if not applicable* _____

Is your child under the care of an MD at this time? □ Yes □ No *(If yes, please complete the line below)*

Name of the Pediatrician/MD: _____

Location: _____

Phone:_____ Fax: _____

If no, when and where did you last receive health care?_____
For what reason?_____

Is there a pharmacy you pick up prescriptions from regularly?

Pharmacy name

Pharmacy Phone number:

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HIPAA Notice of Privacy Practices

Please review this notice carefully. It describes how medical information about you may be used *and disclosed and how you can get access to this information.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 15, 2011.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Dr. Shalini Almeida in person or by phone at our main phone number.

Signature Below is only an acknowledgment that you have received this Notice of our Privacy Practices:

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Legal Guardian	Signature	Date

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CONFIDENTIAL CONTACT INFORMATION

Legal Name:_____ Date:_____

Preferred Name (if applicable):_____ DOB: _____ Age: _____ Sex/Gender: ____

Home Address: _____

Phone: (Home)_____ (Cell)_____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

COMMUNICATION

What is the best way to communicate with you between office visits? □Email □Home phone □Cell Ph

May we leave detailed messages on your preferred phone voicemail? □Yes □No

Do you wish to communicate with the doctor via email*? □Yes □No

E-Mail Agreement

Dia Natural Health Care may use e-mail to correspond with patients as a convenience. This communication is **only for brief questions you might have following an immediate appointment.** I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose;
- System operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of the medical record at Dia Natural Health Care. It is extremely important to include my name on each and every e-mail sent to the clinic.
- Since e-mail may not be monitored while Dr. Shalini Almeida is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response **within one week.**

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use. I have been provided with information about the use of e-mail communications between myself and Dia Natural Health Care, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting Dia Natural Health Care.

I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address:

Please print e-mail address clearly:_____

Printed Name: _____Signature:_____ Date:_____

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INSURANCE

Insurance? □Yes □ No Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number: _____

Primary Insured: _____ DOB of primary Insured: _____

Patient relationship to primary insured: _____

Secondary Insurance? □ Yes □ No Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number: _____

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits on my behalf to directly to Dr. Shalini Almeida, ND, BHMS for any services provided to me at Dia Natural Health Care, LLC.

Payment Agreement

Please read and **initial** the following statements. Feel free to ask if you have any questions about our policies.

_____Payment for all services and dispensary items is due at the time of the visit. Payment may be made by cash, check, Visa, or MasterCard. Returned checks will be subject to a $35.00 fee.

_____ I am responsible for all charges of all services provided. In the event that my insurance company denies benefits, makes a partial payment, or fails to make payment within 90 days, I am responsible for any balance due.

_____ **It is my responsibility to provide 24 hours notice by phone to cancel or change appointments, unless I have an emergency. I understand that I am responsible for paying the full amount for the missed appointment. This cancellation fee cannot be billed to the insurance is entirely my responsibility.**

_____ Dr.Almeida may prescribe medicine/supplements, which may be purchased at Dia Natural Health Care or elsewhere. Most insurance companies do not cover the cost of herbs/homeopathic medicines/supplements etc. If such items are dispensed at the clinic payments need to be made in full at the time of purchase.

_____ In addition to the fees quoted above, you will be responsible for expenses incurred in connection to your health care provided at Dia Natural Health Care. Such expenses may include postage, phone calls to our office wherein medical advice is provided to you (other than brief clarifying questions regarding your current treatment plan), or laboratory fees.

I have read and understand the above-stated policies of Dia Natural Health Care, LLC and will comply with them in all respects.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

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Informed Consent and Request for Naturopathic Medical Care

At Dia Natural Health Care we believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for them. The way in which we choose to treat people will often be different than the conventional care of your MD. It is our policy to always present you with information about your condition, the procedure being performed, any risks, and alternative treatments available to you. If our explanation is not to your satisfaction, please ask for more information. Treatments at Dia Natural Health Care include multiple therapeutic procedures as described below.

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Shalini Almeida, ND having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and give my voluntary and informed consent for naturopathic care by Dr. Shalini Almeida, ND and/or other licensed doctors of naturopathic medicine serving as backup for her, to perform the following procedures as necessary to facilitate my diagnosis and treatment:

I understand that a Naturopathic evaluation and treatment may include, but are not limited to: Physical exam (including general, musculoskeletal, HEENT, Heart and Lung, Gynecological, Abdominal, Endocrinal, Urological, Orthopedic and Neurological assessments)

- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections, IV therapy)
- Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities
- Psychological counseling is provided for the support of improved lifestyle strategies.
- Soft tissue and osseous manipulation (including therapeutic massage, strain-counterstrain, Bowen therapy, naturopathic/osseous manipulation of the spine and extremities, muscle energy technique and cranio-sacral therapy)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)
- Minor office procedures**:** use of local anesthetics, repair of superficial lacerations, drain & pack abscesses in the dermis & subcutaneous tissue, remove superficial lesions, moles, lipomas, warts, nevi, ganglions, fibromas, cysts, foreign bodies, excision & biopsy, stitch surgical & non-surgical wounds, debride wounds, escharotic therapy – warts, moles, cervical lesions, punch biopsies, scar therapy, removal of impacted cerumen (ear cleansing), wound & decubitus ulcer care.

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I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Shalini Almeida and/ or with the providers providing backup, regarding:
(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I recognize the potential risks and benefits of these procedures as described below:
Potential benefits: Restoration of health and the body's maximal and optimum functional capacity, relief of pain and other symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; inconvenience of lifestyle changes; aggravation of pre-existing conditions.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Shalini Almeida of these conditions.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that the record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Legal Guardian	Signature	Date