Hello and Welcome

Thank you for choosing Sonora Naturopathic. We know you have choices when it comes to your healthcare and we are dedicated to providing out patients with the best care possible.

Enclosed you will find new patient forms. Before your scheduled appointment, please carefully read and fill out the enclosed forms. We know your time is valuable and bringing your completed patient information forms with you will maximize the amount of time spent with the doctor.

Your first visit will be an assessment of your health lasting approximately 1 hour or more. The fee varies and is based on time; feel free to call the office if you need more information.

If you are unable to keep your scheduled appointment time please call as soon as possible so that we may reschedule your visit.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications you are currently taking.

We look forward to supporting you in your healing journey.

In Health,

Sonora Naturopathic

Sonora Naturopathic

General Intake Form

(Parents, fill out your answers to these questions.)

1. What are your expectations of the first visit?
2. What are your expectations of me in the first visit?
3. What are your expectations of the time it will take to recover your child's health?
4. Is there anything you will not do or change? Your child?
5. What is your commitment level 0-10 to your recovery? Why?
6. What obstacles do you see to you and your child achieving optimal wellness?
7. Who do you have to support you through your child's recovery?
8. What do you see that you/your child do everyday that supports or diminishes your/your child's wellness?
9. What is your lifestyle?
10. What is your/your child's typical day-to-day schedule?

Sonora Naturopathic

WELCOME to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Patient ID# ______________Today's Date________________

Your Child

Child's Name______________________________

Nickname________________________ Sex ______

Birthdate ________________________ Age ______

Soc. Sec. # ________________________________

School ________________________Grade ______

Child's Home Address _______________________

____

City, State, Zip _____________________________

Phone: ___________________________________

Responsible Party

Name_________________________________

Relationship____________________________

Address _______________________________

City, State, Zip _________________________

Soc. Sec. # ____________________________

DL# __________________________________

Email _________________________________

☐ **Mother** ☐Stepmother ☐Guardian

Name__________________________________

Home phone ____________________________

Cell Phone _____________________________

Employer ______________________________

Occupation _____________________________

Soc. Sec. # _____________________________

DL# __________________________________

Email:_________________________________

☐ **Father** ☐Stepfather ☐Guardian

Name______________________________

Home phone _________________________

Cell Phone_________________________

Employer ___________________________

Occupation _________________________

Soc. Sec. # _________________________

DL# ______________________________

Email:______________________________

Parent's Marital Status

☐Married ☐Divorced ☐Single
☐Widowed ☐Separated

Who is responsible or making appointments?

Name _____________________________
Home Phone________________________
Work Phone ________________________
Best time to call
Time __________ Days _______________

Financial Arrangements

For your convenience, we offer the following methods payment. Please check the option which you prefer.
Payment in full at each appointment.

___Cash ___Personal Check ___Credit Card Visa MC
___I wish to discuss the office's payment policy.

HEALTH HISTORY
CONFIDENTIAL

Child's Name______________________________ Birthdate ____/____/_____ Patient ID# _________

Your child's overall health as well as any medications your child takes could have an important interrelationship with the care your child receives. Please answer each of the following questions completely.

Personal Information

Please check any problems your child currently has or ever has had.

Thumb Sucking ☐Yes ☐No
Toilet Training Problems ☐Yes ☐No
Diarrhea or Constipation ☐Yes ☐No
Irritable/Temper Problems ☐Yes ☐No
Nightmares/Sleep Problems ☐Yes ☐No
Feeding or Eating Problems ☐Yes ☐No
Meals each Day ____________# Snacks _________
Does your child take vitamins, fluoride, iron, or other supplements? ☐Yes ☐No
Is your water fluoridated? ☐Yes ☐No
Does your child get along well with other children? ☐Yes ☐No
Is your child doing well in school? ☐Yes ☐No
Has your child ever eaten dirt, paint or plaster? ☐Yes ☐No
Did the mother use any cigarettes, alcohol, drugs, or medications during pregnancy? ☐Yes ☐No

Dental Problems ☐Yes ☐No
Bed Wetting ☐Yes ☐No
Eye Problems ☐Yes ☐No
Speech Problems ☐Yes ☐No
Hearing Problems ☐Yes ☐No
Emotional Problems ☐Yes ☐No
Discipline Problems ☐Yes ☐No
Developmental Problems ☐Yes ☐No
Alcohol/Drug Abuse ☐Yes ☐No
Child's weight at birth__________________
Delivery ☐Vaginal ☐C-Section
Was your child born more than two weeks early or late? ☐Yes ☐No
Was/is child breast-fed? ☐Yes ☐No
Age Discontinued ____________________

Health History

Has your child ever had:

Mumps, Measles ☐Yes ☐No
Chicken Pox ☐Yes ☐No
Eczema/Skin Problems ☐Yes ☐No
Pneumonia ☐Yes ☐No
Asthma/Wheezing ☐Yes ☐No
Cancer ☐Yes ☐No
Hepatitis ☐Yes ☐No
HIV/AIDS ☐Yes ☐No
Hemophilia ☐Yes ☐No
Abnormal Bleeding ☐Yes ☐No
Allergies ☐Yes ☐No
Frequent Ear Infections ☐Yes ☐No
Frequent Colds or Sore Throats ☐Yes ☐No

Croup ☐Yes ☐No
TB/Lung Disease ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
Kidney/Bladder Problems ☐Yes ☐No
Sexually Transmitted Disease ☐Yes ☐No
High Cholesterol ☐Yes ☐No
Handicaps/Disabilities ☐Yes ☐No
Diabetes ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No
Congenital Heart Defect ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Convulsions/Epilepsy ☐Yes ☐No
Emotional Disorders or Suicide Attempts ☐Yes ☐No

Please explain any medical problems that your child has ____

____

____

Hospitalizations or Serious Illnesses

Please list any hospitalizations, serious and/or unusual illnesses which your child has experienced.

Date(s)	Hospitalization/Ilness	Hospital/Physician's Name	City, State

Medications

Please list all medications your child currently takes

Date	Medication/Strength	Frequency	Condition

Allergies

Please list allergies, sensitivities, and/or reactions to any drugs.

____

____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child’s health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services my child may need.

____
Signature of parent or guardian Date

Doctor's Review ____

____

____
Doctor's Signature Date