

THE NEW LIFE CENTER
Gil Alvarado, N.D., L.Ac., Dipl.Ac. (NCCAOM)
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CHILD HEALTH HISTORY FORM

	Date of 1st Appointment _____
Name _____	Gender M___ F___ Birth Date _____ Age _____
Name your child likes to be called _____	Height ___ft ___ in Weight _____ pounds
Address _____	City _____ State _____ Zip _____
Mother's Name _____	email address: _____
Home Phone _____	Work Phone _____ Mobile Phone _____
Father's Name _____	email address: _____
Home Phone _____	Work Phone _____ Mobile Phone _____
Who Told You About The New Life Center / Dr. Alvarado? _____	

Please list what you want to achieve for your child at The New Life Center:

What problems, difficulties, illnesses, or complaints would you like remedied?

Has your child ever received health care or treatment from a:

- Naturopathic Physician
 Acupuncturist
 Other "Natural Practitioner"

Please check any that have been a problem for a parent, grand-parent, sister, brother, aunt or uncle:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> arthritis | <input type="checkbox"/> kidney disease | <input type="checkbox"/> thyroid/adrenal |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke | <input type="checkbox"/> heart problems | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> celiacs | <input type="checkbox"/> epilepsy | <input type="checkbox"/> asthma | <input type="checkbox"/> mental disorder |
| <input type="checkbox"/> alcoholism / addiction | <input type="checkbox"/> autoimmune or inherited _____ | | |

Please check any of the following your child is exposed to:

- | | | | |
|------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> dust | <input type="checkbox"/> mold | <input type="checkbox"/> dampness | <input type="checkbox"/> fumes |
| <input type="checkbox"/> chemicals | <input type="checkbox"/> paint | <input type="checkbox"/> solvents | <input type="checkbox"/> insecticides |
| <input type="checkbox"/> varnishes | <input type="checkbox"/> lacquers | <input type="checkbox"/> excessive heat | <input type="checkbox"/> excessive cold |

**Please UNDERLINE any of the following your child has experienced in the past,
and
Please CIRCLE any which your child currently or has recently experienced:**

- | | | | |
|---|------------------------|--------------------------|----------------------|
| fear | phobias | nervousness | extreme stress |
| extreme pain | insomnia | grief | guilt |
| loneliness | nightmares | irritability | low self-esteem |
| lack of confidence | angry outbursts | "hyper" behavior | insensitive behavior |
| compulsiveness | depression/disinterest | trembling | shallow breathing |
| cold sweats | confusion | difficult concentration | fever |
| asthma | allergies | skin condition | head injury |
| bone/joint disease | jaundice | hepatitis | mononucleosis |
| appendicitis | seizures | headaches | migraines |
| yeast problems | thrush | diabetes | cancer |
| broken bones | back pain | neck pain | major injury |
| unusual change in appetite | | unusual change in weight | |
| food, chemical, or drug poisoning | | night sweats | muscle twitching |
| unusual lumps | enlarged glands | abnormal discharges | abnormal bleeding |
| dizziness | loss of balance | abnormal sensations | eye pain |
| tearing eyes | ringing ears | nosebleeds | wheezing |
| short of breath | chest pain | irregular heart beat | swelling or edema |
| difficulty swallowing | stomach problems | digestive problems | mouth sores |
| intestinal disease | bowel problems | food intolerances | kidney problems |
| urinary symptoms: frequency, urgency, bed wetting, other urinary symptoms | | | |

Does your child have any other health problem or condition you wish to mention?

YES

NO

Does your child follow any special way of eating?

Please explain: _____

Are you aware of your child having any allergies?

Please explain: _____

Has your child ever been hospitalized or had surgery?

Please explain: _____

Is your child receiving care for their well-being now?

From whom? _____

For what purpose? _____

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, and any other supplements or remedies which your child is using now. Please indicate what s/he is using them for, how much s/he uses, and how long s/he has been using them. Thank You.

What is used

What it's for

How much used

How long used

Thank you for taking the time to complete this form. It will help me to help your child. I look forward to meeting with both of you.

Gil Alvarado, N.D., L.Ac., Dipl. Ac.

Appointments and Payment

We have found it is best to be sure that everyone is clear about appointment and payment policies before their first appointment. The policies are simple. This note is to insure your understanding. If you have any questions or concerns please call The Center and we will answer them for you.

Your child's first appointment at The Center will be about 1.5 hours. The fee is \$145. Future visits will be about 3/4 hours and the fee is \$95. Nutritional supplements and herbal remedies, etc. are charged separately. If for any reason you are unable to keep an appointment please give us as much notice as possible, and at least call 24 working day hours before the appointment (ie. call by 10:00 AM on Friday for a 10:00 AM Monday appointment) or you will be responsible for full payment. We regret that past experience has made this policy necessary.

Full payment is due at the time services are rendered. Should this ever not be possible, please make specific financial arrangements with us before your visit. We do not routinely send bills for services. If you have insurance that covers our services, the receipt you receive from us will have all the information your insurance company needs to reimburse you. We do not accept payment directly from insurance companies. If you have any questions please call us and we will be happy to answer them for you.

Thank you again for bringing your child to The New Life Center. I appreciate and value the privilege of serving your child and will do my best to help your child receive the assistance they need and deserve.

Please sign and date this form and email or fax it to us with your child's Health History Form. Thank you.

I have read and agree to the information and policies described above.

Name (please print) _____

Signature _____ Date _____

Relationship to child _____