

THE NEW LIFE CENTER
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PEDIATRIC HEALTH HISTORY FORM

Name _____ Date of 1st Appt. _____
Name your child likes to be called _____ Height _____ Weight _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Birth Date _____ Age _____ Gender M ___ F ___
Mother's Name _____ Hm. Ph. _____ Wk. Ph. _____
Father's Name _____ Hm. Ph. _____ Wk. Ph. _____
Who Told You About The New Life Center? _____

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 _____ an Acupuncturist _____ any other "Natural Practitioner" _____

Please circle any of the following that any direct family member has had: Cancer; Diabetes; Heart or circulatory problems; Epilepsy; Nervous or mental disorder; Asthma; Arthritis; Thyroid problems; any inherited diseases _____

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

- | | | | |
|-----------|----------|----------------|----------------|
| dust | mold | dampness | fumes |
| chemicals | paint | solvents | insecticides |
| varnishes | lacquers | excessive heat | 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 | difficulty swallowing |
| swelling or edema | stomach problems | digestive problems | mouth sores |
| intestinal disease | bowel problems | food intolerances | kidney problems |
| urinary symptoms: | frequency, urgency, dribbling, | difficult starting or retaining | |

Does your child have any other illness, 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 any care for physical 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 1½ hour. The fee is \$125. Future visits will be about ¾ hour and the fee is \$85. 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. If you can't keep your child's appointment, call at least 24 working day hours before their appointment, or you will be responsible for full payment. (call on Friday if you can't keep a Monday appointment, etc. – weekends and national holidays are not working days) 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 *prior* to 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 The Center 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 you and will do my best to help your child receive the assistance they need and deserve.

Please sign and date this form and mail 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 _____