Whispering Lotus Healing Center
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4222 W. Emerald St., Boise, ID 83706
208-901-8556
www.whisperinglotus.com

Dear Patient,

Welcome to Whispering Lotus Healing Center!

The following document is our **New Patient Pediatric Intake Form for children under 18 and those who have not started menstrual cycles.**

1. Please print this document, complete it as best you can, and bring it with you to your appointment.
    - If you are unable to print out the Intake Form, please contact our office at 208-901-8556 to discuss other options.
    - Please allow ~ 30 minutes to complete the New Patient Intake Form & read the follow.
2. NAET allergy desensitization patients please read NAET Instructions and signed the NAET Informed Consent.
3. You are welcome to bring recent **laboratory reports** related to the treatment conditions you are seeking support for.
    - To request records transferred from other providers, you can find a Release of Records form on our web page.
4. Please be conscientious and avoid fragrances. When you visit our office, please do not wear scents that are perceptible by others, such as: perfume, cologne, scented hair spray, scented deodorant, scented lotion, or strong essential oils. We appreciate your respect to our chemically sensitive patients and staff.
5. Please review and sign our Fees and Services and HIPPA policies.
6. Please be aware of our **Cancellation Policy:**
    - You may cancel or reschedule at *no charge* if you call **at least 24 hrs (1 business day)** before your appointment. If notice is given less than twenty-four hours, you will be charged **half price of the visit**.

If you have any questions, please contact us at 208-901-8556. Office hours are 9 to 5 Monday to Thursday. Responses will be made the next business day.

Thank you! We look forward to meeting you and helping you on your journey to good health!

4222 W. Emerald Street, Boise, ID 83706 | office 208-901-8556 | WhisperingLotus.com

PEDIATRIC PATIENT INTAKE FORM

Today's Date________________

PERSONAL INFORMATION

Child's Full Name____

Age______________________ Date of Birth_______________________________ Gender_______________

Parent's A's Name__________________________Parent B's Name________________________________

Child lives with ____

Mailing Address____

City_____________________________________State_______________________Zip_________________

Address of other parent (if different from above)____

____

Parent A's phone (home)____________________(work)_____________________(cell)_______________

Parent A's Email____

Parent B's phone (home)____________________(work)_____________________(cell)_______________

Parent B's Email____

Current school ____ Grade _____________________

How did you hear about our clinic?____

Would you like to receive our Monthly Email Newsletter with health news and event listings? Y N

MEDICAL HISTORY

List current health concerns in order of importance:

____

____

____

List all prescription medications, nutritional supplements, herbs, or homeopathic remedies currently being taken. Please list doses if known.

____

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Please list any medications, natural or prescription, your child has taken in the past:__________________

____

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Allergy to any medicines, if so what?____

____

List past surgeries or hospitalizations. Please list age.

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____

Blood type (A/B/O)____

Has your child been immunized?______If so, has the recommended schedule been followed?__________

If not, please explain____

Has there been any negative reaction to vaccinations?____

FAMILY MEDICAL HISTORY

Do any close relatives (grandparents, parents, siblings) have any of the following medical conditions?

Please circle which applies:

High Blood Pressure, Heart Attack, Stroke, Obesity, Diabetes, Glaucoma, Asthma, Hayfever, Eczema, Skin Disease, Food Allergies, Emphysema, TB, Lung Cancer, Breast Cancer, or other Cancer, Birth Defects, Suicide, Depression, Mental Illness, Alcoholism, Epilepsy, Ulcers, Arthritis, Gout, Thyroid Disease, Easy Bleeding, Sickle Cell Anemia, Osteoporosis

BIRTH HISTORY

Birth order of this child______________Number of siblings_____________________________________

Where there any complications during pregnancy or labor and delivery? Please explain._______________

____

DIET

How was your child fed as an infant?   Breast fed?_________________How long?_________________

Formula?__________________Type?_____________________

What age did your child begin eating solid foods?____________Which foods?______________________

Any unusual reactions to solid foods as an infant ?____

Please describe your child's typical daily diet. If breastfeeding, describe mother's diet.

Breakfast ____

Lunch ____

Dinner____

Snacks____

Drinks____

Does your child eat school prepared meals or snacks?____

Which foods, condiments, flavors does your child crave?____

____

Which foods, condiments, flavors does your child dislike?____

____

Does your child have any food sensitivities or intolerances, either current or in the past?___________________________

____

Is there anything you wish to discuss about behavior or emotions? If so, please explain. ____________

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Is there anything else you wish to add?____

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Thank you for taking the time to complete this form.