Hello and welcome!

Thank you for choosing The Natural Path. We know you have choices when it comes to your healthcare and we are dedicated to providing patients with the best care possible. Attached you will find new patient information forms. Before your scheduled appointment, please carefully read and fill out the forms. I 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 a thorough assessment of your health lasting approximately 90 minutes.

If you are unable to keep your scheduled appointment time for any reason, please let us know 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, to your office visit.

We look forward to supporting you on your journey to health.

Warmest Regards,

The Natural Path

~ The Natural Path ~ Paul R. Raish, N.D. ~515 Kirkland Way, Kirkland, WA 98033 ~
Phone ~ 425-828-4000 ~

The Natural Path
PEDIATRIC QUESTIONAIRE
All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

(PLEASE PRINT)

Today's Date_____/_____/_____

Child's Name________________________________ Date of Birth_____/_____/_____
Age_______ Sex: □ Male □ Female
Address _________________________ City ____________ State __________ Zip __________

Parent or Guardian Contact Information:
Name____
Relationship to Child__________________________________
Address ____ City _________________
State _________ Zip _________
Home Phone _________________ Cell or Alternate Phone #___________________
Email____________________
How did you hear about us? _____________________________________

Health History

What is the child's main reason for seeing the doctor today? If there is a specific health condition, please describe it in detail including the first time you noticed your condition. Please list any factors you suspect may have played a role in its onset and continuation.

____
____
____
____

How long has the main problem been an issue?
____

List in order of importance other health problems that are an issue:
1.____
Length of Time ______________________________
2.____
Length of Time ______________________________
3.____
Length of Time ______________________________
Who is the child's pediatrician?
Name ____
Phone ______________________________
Have the child ever seen a Naturopathic Physician, Chiropractor, Acupuncturist or other alternative healthcare provider? (circle yes / no)
Who was the practitioner and what were the results?
____

How would you describe the child's overall state of health?
(circle one) *Excellent, Good, Average, Fair, Poor*
What is the child's blood type? __________
Does the child now, or in the past, experience(d) the following:
(circle all that apply)
Anemia Hepatitis Bladder infections Hernia
Bleeding Tendency
Blood Clotting Disorder AIDS or HIV+ Chickenpox Asthma
Epilepsy Ear infections Blood Transfusion Thyroid Disease Hives or Eczema
Gastric reflux Bed wetting Thrush or Candida Teething Difficulties
Any Other Condition (please list):____
Previous Hospitalizations/Surgeries/Serious Illnesses
Date: _______________________ City/state _________________________________
Date: _______________________ City/state _________________________________
Date: _______________________ City/state _________________________________

Family History
Please list ages, health problems, and if deceased please indicate cause of death:

Relationship	Age	Age at Death	Significant health problems or cause of death:	Children's Age	Age at death:	Significant health problems or cause of death:
Father				□ M □ F		
Mother				□ M □ F		
Brothers And sisters □ M □ F				□ M □ F		
□ M □ F				Grandparents (mother's Side)		
□ M □ F				Male		
□ M □ F				Female		
□ M □ F				Grandparents (Father's side)		
□ M □ F				Male		
□ M □ F				Female		

Does the child have known allergies to any drugs, foods, animals, herbs or other substances? Please list allergen and the reaction to it:
____

Medications:
(please give full name, strength, dosage, indication and how long you have been taking the medication)

____
____
____
____
____
____

Vitamins or Herbs:
(please give full name, strength, dosage and how long you have been taking the supplement)

____
____
____
____
____
____

Birth History:

At how many weeks gestation was the child born? _______
Was it a vaginal birth or a C-Section? _____________
How much did he/she weigh? _______
How long was he/she? _______inches
Were there any birth complications?____
Was the child breast fed? _______ If yes, for how long? ___________________
Were there any difficulties introducing foods? If yes, which foods and what were the difficulties?

____

Immunization History

Has the child had all immunizations?
□ Yes □ No
If yes, please check all that have been administered:
□ Hep B □ DTaP or DTP □ Hib □ Polio □ MMR □ Varicella
□other___________________
Were there any reactions or complications from the immunizations?
____
Is there anything else we need to know?
____
____

Financial Policy

Thank you for choosing The Natural Path where we are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read, sign and return to us prior to your treatment. Naturopathic Medicine may be covered by some PPO plans. Check with your insurance company to determine if this is a covered benefit. The Natural Path does not submit billing claims at this time. A superbill will be provided for you to send in to your insurance company for reimbursement. However, HMOs do not reimburse for services provided by Naturopathic Physicians.

Returned Checks

For checks returned to us as unpaid by your bank, you will be charged a ***$25 fee***.

Missed Appointments

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge ***$25 for missed appointments without appropriate notice***. Please help us to serve you better by keeping scheduled appointments.

Payment Plans

If you are unable to pay your balance in full at the time of your visit, payment arrangements may be made. Please discuss your situation with Dr. Raish so he can create a plan for you

Past Due Accounts

If a payment plan is not in place and your account becomes overdue, your account will be referred to a collection agency. Legal fees that we incur to secure past due balances will be added to your account.

Consent to Treat

I consent to the use and/or disclosure of my protected health information by The Natural Path for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my physician is a licensed Naturopathic Physician. I understand and agree that diagnosis or treatment of me by The Natural Path and my physician may be conditioned upon my consent as evidence by my signature on this document. I understand that I am financially responsible for the charges that I incur during my treatment under the care of The Natural Path. I have read and agree to the financial policy. As the child's parent or guardian I understand that I am consenting for my child to be treated. Please request a copy of our Privacy Practices if you have any questions or concerns.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ANY SERVICES, SUPPLEMENTS, MEDICINES, AND LABORATORY WORK.

Print Name of Parent/Guardian____

Signature of Parent/Guardian____

Date__________________