Kelly Austin, ND
Natasha Monterey, ND
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858.675.7072

Pediatric Confidential Health Record

Contact Information

LAST NAME	FIRST NAME		TODAY'S DATE MM DD YY
HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
Permission to leave messages: Y N	DATE OF BIRTH - -	GENDER: FEMALE MALE	AGE

EMERGENCY CONTACT NAME	PHONE
Who is filling out this form? (name & relation)	Who does the child live with?
How did you hear about our clinic?	PRIMARY MEDICAL PHYSICIAN NAME / PHONE

List other healthcare providers with office phone numbers:

CURRENT STATUS

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1	4
2	5
3	6

Usual Health: Excellent Good Fair Poor	Time of highest energy during the day: Morning Afternoon Evening
Energy: Good Fair Poor Varies	Time of lowest energy during the day: Morning Afternoon Evening

Medications: please list prescription medication, over-the-counter medications and supplements taken regularly:

NAME	REASON	DOSE	START DATE	SIDE EFFECTS

PRIME WELLNESS

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DIET

How was your infant fed?

☐ Breast fed. How long? _____

☐ Formula. Milk/Soy/Other: _____

Veg: _____ Fruit:_____

Grain: _____ Bean/meat: _____

Sweets: _____ Concerns: _____

_____

Did your child ever experience colic? Y N

How severe? mild moderate severe

Describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity)_____

_____

ELIMINATION

BM Freq: _____ Appearance: _____

Urinary freq:_____ Toilet training: _____

Concerns: _____

SLEEP

Hrs/night: _____ Naps freq: _____ Amt: _____

Where: _____ Habits: _____

Concerns: _____

_____

GROWTH & DEVELOPMENT

Stand	Y N	Scribble:	Y N
Walk:	Y N	Feed Self:	Y N
Run	Y N	Wave bye bye:	Y N
Dada/mama specific:	Y N	Drink from cup:	Y N
Number of words:	___	Use spoon /fork:	Y N
Imitate speech:	Y N	Remove clothes:	Y N

BEHAVIOR/PERSONALITY

Has your child's genetics been tested? Y N

Do you give our office permission to run genetics? Y N

Describe child: _____

_____

Temper tantrums: Y N How managed? _____

_____

Discipline (reasons, methods) _____

_____

Adaptable Y N Plays well w/others Y N Shares: Y N

Aggressive: Y N How managed: _____

TV/day: _____ Read to daily: Y N

Concerns: _____

How would you describe your child's behaviour and performance at school? _____

FAMILY/SOCIAL

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

Does anyone in the child's household drink? Y N Who?____

Dental care: Y N

Concerns: _____

DAY CARE

Y N Where: _____

Freq/Length: _____

Concerns: _____

VACCINATION STATUS

1. Is your child up to date on their vaccinations? Y N
2. If not, what vaccinations (if any) have they received?

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

Environment

What are your child's favorite activities?

_____

_____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?

Please describe: _____

How was your child's health in the first year?

Poor Fair Good Excellent Unknown

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Prenatal Health

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma

Other _____

_____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries _____

☐ Birth defects _____

☐ Other _____

Is there anything that you feel is important that has not been covered?

_____

_____

Dr. Kelly Austin, ND
Dr. Natasha Monterey, ND
atmyprime.com 858.675.7072

OFFICE POLICIES

Hours Rancho Bernardo
Monday- Friday 9am-5pm

Hours Solana Beach
Monday / Tuesday / Thursday 9am-5:30pm
Wednesday & Friday 9am-1:00pm

Office visits are by appointment only.
B12 walk-ins welcomed!

Fees

$375 Initial Appointment (55 min)
$375 1st follow-up (55 min-Dr. Austin)
$275 1st follow-up (55 min)
$125 follow-up (25 min-Dr. Austin)
$99 follow-up (25 min)
$70 follow-up (15 min)

Payment

• Payment is due at the time of service. Please discuss any fee questions with the doctor before your visit so you can know what to expect.
• We accept cash, check or credit cards.
• Lab testing is not included in the fee. If you have a PPO, we will use a lab facility that is covered by your insurance company. If you have a HMO, we can ask your HMO MD to run the labs we need.
• Fee schedules can be arranged with the doctor prior to a visit if you are in financial need.

Insurance

- Insurance does not directly cover naturopathic doctors.
- However, we can provide you with a superbill after every visit which you may submit to your insurance company to request out-of-network reimbursement. Some services may not be covered by certain health insurance plans.
- It is your responsibility to know what your insurance plan covers.
- We are not responsible for unpaid claims by your insurance company for services we provide.

Phone Consults

- We will call you for your scheduled appointment. Please allow a 5 to 10 minute window of buffered time.
- All appointments are scheduled for the Pacific Standard Time.

Cancellations

- As a courtesy, our office will e-mail or call you to confirm your appointment 1 business day in advance.
- If you cannot keep a scheduled appointment, please notify us at least 24 hours prior to your scheduled time.
- If you miss your appointment without cancelling, you will be charged for the missed appointment.

Appointments

- First appointment: Please fill in the new patient forms prior to your appointment. You may bring them with you to your appointment or fax them in.
- Please arrive 15 minutes before your scheduled appointment.
- Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, perfumes, cologne and hair spray.
- Follow-up consults may be scheduled in 15, 30, 45, or 60 minute blocks, depending on your needs.
- All consultations are charged for the time used, not the time blocked.
- Research requested by the patient is a billable service and will be charged at the hourly rate.
- Follow-up visits: We generally recommend that all patients have a follow-up every 3 months at minimum.

Prescriptions

- Prescriptions need to be obtained at your appointment. We do not mail prescriptions or lab orders.
- We require 24-hour notice for refills.
- Hormone prescriptions are done on a 3 month basis, and require a follow up to renew them.
- Please come to all appointments prepared with a complete medication list and let us know which require refills.
- No prescription dose change will be made without an appointment.
- If you are sick or have side effects, please contact us immediately.
- The doctor cannot prescribe medications to those who are not his or her patient.

Tests

- If you misplace an order for testing, we require 24-hour notice to rewrite the order. You can pick it up at the office or we can e-mail it to you.
- Tests will not be discussed via phone unless it is a phone consult.
- Results are only discussed at appointments and not outside the office to prevent unsafe disclosure of the confidential health information.

Medical Letters

- Medical letters (for schools, insurance companies, etc) can be provided. The charge for generating these will be billed at the doctor's hourly rate.

Follow-Up Questions

- You can contact the doctor with follow-up questions, but please keep these brief. If a question is more involved, a consult may be required.

General

- Please keep all health concern discussions to office visits.
- Please avoid discussing other people's health concerns at the visit. You have limited time with the doctor and we want to make sure you get the time and attention needed to make you feel better.

The policies listed above have been established to ensure quality care for our patients. Should you have any questions, please contact our office.

PRIME WELLNESS

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Informed Consent to Telemedicine Consultation

Telemedicine involves the use of electronic communications to enable our patients to choose whether they would like their consultations to be in person or over the phone, this helps to improve patient care. The information may be used for diagnosis, therapy, follow-up and/or education.

Confidentiality: At Prime Wellness all reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation.

Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.

I agree to participate in telemedicine consultations with Prime Wellness.

Signature: _____

Date: _____