



Liz Wallace, ND, LAc, MSOM

Naturopathic Physician • Licensed Acupuncturist

## Confidential Health History and Pediatric Intake

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: (Father) \_\_\_\_\_ (Mother) \_\_\_\_\_ (Guardian) \_\_\_\_\_

Address: (Street / PO Box) \_\_\_\_\_ (City / State / Zip) \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work with Extension) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

SSN: \_\_\_\_\_ Parent/Guardian SSN: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name and Address of Doctor's Office/Hospital/Clinic Where Your Child's Health Records are Kept::

Office/Hospital/Clinic: \_\_\_\_\_

Address: (Street / PO Box) \_\_\_\_\_ (City / State / Zip) \_\_\_\_\_

## What Are Your Child's Concerns For Which You Are Seeking Healthcare? (List Primary Concern First)

1. \_\_\_\_\_

Date of Onset: \_\_\_\_\_

2. \_\_\_\_\_

Date of Onset: \_\_\_\_\_

3. \_\_\_\_\_

Date of Onset: \_\_\_\_\_

4. \_\_\_\_\_

Date of Onset: \_\_\_\_\_

Are You Seeking Primary Care from Dr. Liz Wallace? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, Who is Your Primary Healthcare Physician? (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_

For What Concern Did Your Child Last Receive Medical Healthcare? \_\_\_\_\_

Date of Care: \_\_\_\_\_

## Medications

	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-Histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to Medicines	_____	_____

## Medical History

### Has Your Child Had Any of the Following?

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Mumps	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Croup
<input type="checkbox"/> Rubella	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other (Please List)

### Has Your Child Had Any of the Following Tests?

Electroencephalogram:	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Results: _____
Psychological evaluation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Results: _____
Hearing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Results: _____
Speech/Language:	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Results: _____

Injuries/Surgeries/Hospitalizations (please list): \_\_\_\_\_

## Immunizations

Measles     Polio     MMR     Smallpox     Diphtheria     Mumps     DPT  
 Tetanus     Influenza

Others (list) \_\_\_\_\_

Any Adverse Reactions?  Yes  No    What? \_\_\_\_\_

## Family History

Heart Disease     Diabetes     Birth Defects     Hypertension     Arthritis     Cancer  
 Tuberculosis     Allergies     Mental Illness

## Prenatal History

Previous Pregnancies by Natural Mother, Miscarriages or Complications? \_\_\_\_\_

Mother's Age at Child's Birth? \_\_\_\_\_

### Mother's Health During Pregnancy?

Bleeding     Physical/Emotional Trauma     Nausea     Nicotine/Alcohol/Drug Consumption  
 Illness     Hypertension     Thyroid Problems     Diabetes

## Birth History

Term: Full \_\_\_\_\_    Premature \_\_\_\_\_    Late \_\_\_\_\_    Weight at birth \_\_\_\_\_

Length of labor: \_\_\_\_\_    Complications? \_\_\_\_\_

### Did Your Child Have Any of the Following Problems Shortly After Birth?

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Birth Injuries	<input type="checkbox"/> Blue Baby	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Seizures
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colic	<input type="checkbox"/> Fever	<input type="checkbox"/> Rashes	

## Birth History (Continued)

Other (Explain) \_\_\_\_\_

Child's Sleep Patterns (First Year) \_\_\_\_\_

Food Intolerances (if Any) \_\_\_\_\_

Feeding: Breast Fed? \_\_\_ How Long? \_\_\_\_\_ Formula? \_\_\_ Milk / Soy

Age Began Solids: \_\_\_ Which Foods? \_\_\_\_\_

Age Began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

## Symptoms

Circle the Response that Applies to your Child:

Y: Present P: Past N: Never

Hives	Y	P	N	Burning of Urine	Y	P	N	Bloody Urine	Y	P	N
Eczema	Y	P	N	Frequent Urination	Y	P	N	Cries Easily	Y	P	N
Bleeding Gums	Y	P	N	Heart Murmur	Y	P	N	Nervous	Y	P	N
Nose Bleeds	Y	P	N	Vomiting Spells	Y	P	N	Sleep Problems	Y	P	N
Acne	Y	P	N	Anemia	Y	P	N	Night Sweats	Y	P	N
High Fever	Y	P	N	Stomach Aches	Y	P	N	Sensitive to Light	Y	P	N
Chronic Rash	Y	P	N	Jaundice	Y	P	N	Body/Breath Odor	Y	P	N
Hearing Loss	Y	P	N	Easy Bruising	Y	P	N	Motion/Car Sick	Y	P	N
Diarrhea	Y	P	N	Flat Feet	Y	P	N	No Appetite	Y	P	N
Sore Throats	Y	P	N	Constipation	Y	P	N	Nightmares	Y	P	N
Gas	Y	P	N	Canker Sores	Y	P	N	Wheezing	Y	P	N
Joint Pains	Y	P	N	Cough	Y	P	N	Dizzy Spells	Y	P	N
Hair Loss	Y	P	N	Frequent Headaches	Y	P	N	Frequent Colds	Y	P	N
Unusual Fevers	Y	P	N	Bleeding Tendency	Y	P	N	Excessive Fatigue	Y	P	N

## Diet

Please describe your child's typical daily diet, including liquids: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Thank You!

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Welcome! We Look Forward to Helping Your Child in Any Way We Can.*



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**Insurance Information, Consent Form, Business Agreement**

1. Release of Records/Payment: I authorize Dr. Liz Wallace to release my medical records relating to claim for benefits submitted. I further agree and acknowledge that I authorize Dr. Wallace to submit claims for benefits for services rendered, without obtaining my signature on each claim. Dr. Wallace uses an insurance billing agency, which will submit my claims. By signing below, I understand that I am financially responsible for all charges incurred for my dependents, or myself at time of service or for services not covered by my insurance company.
2. Cancellation and No Show Policy: By signing below, I understand that, without giving Dr. Wallace 24 hours notice to cancel or change an appointment, full payment for the missed appointment will be due prior to my next appointment.
3. I understand that I may receive naturopathic care, acupuncture treatment, manipulation, bodywork, supplements, herbals, and homeopathic medicines and may be referred for additional lab work. Dr. Wallace will utilize which treatment she feels is best for me, and I accept the risks and benefits to such treatments.
4. The 2007 Fee Schedule is based on "Time of Service" payments, and varies according to the complexity of visit and/or length of treatment.  
 Initial Visit: \$125.00 - \$175.00  
 Return Visits: \$85.00 - \$125.00  
 I understand that, generally, I can expect to have weekly visits for 1 month, followed by bi-weekly visits for 2 months. The schedule may vary based on individual situations, and this timeline gives my body the optimal support for healing.
5. Acknowledgment of Notice of Privacy Practices: I understand that Dr. Wallace may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it. I am aware that Dr. Wallace reserves the right to change the terms of her Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that she may maintain. In the event of amendments, Dr. Wallace will make available a revised Notice of Privacy Practice for my review. I understand that I may also request that some of my health information not be disclosed and understand that Dr. Wallace is not required by law to agree to such request. I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by Dr. Wallace at the following address:

2024 SE Clinton  
Portland, Oregon 97202

Patient, Parent/Guardian (Please sign) \_\_\_\_\_ Date \_\_\_\_\_

Patient Name (Please print) \_\_\_\_\_



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**Insurance Information**

Patient Name \_\_\_\_\_ Insurance ID# \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Email address \_\_\_\_\_  
Name of Insured (if not Patient) \_\_\_\_\_ SSN of Insured \_\_\_\_\_  
Date of Birth of Insured \_\_\_\_\_ Employer \_\_\_\_\_ Insured is:  Male  Female  
Home Address \_\_\_\_\_  
Home Telephone Number \_\_\_\_\_  
Insured Relationship to Patient:  Spouse  Child  Partner  Other \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Phone \_\_\_\_\_ Adjuster \_\_\_\_\_ Claim Number (Workers Comp) \_\_\_\_\_  
ID # \_\_\_\_\_ Group or Plan # \_\_\_\_\_  
Emergency Contact \_\_\_\_\_

Dr. Wallace will happily bill your insurance for your visit\*; however, it is the patient’s responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums.

*\*Please be aware that this is not a guarantee of payment; if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.*

**For Office Use**

1. Beginning Date of Coverage \_\_\_\_\_ Ending Date of Coverage \_\_\_\_\_  
2. Referral from my Primary Care Physician (PCP) for Alternative Services?  Yes  No  
3. Is Dr. Wallace In-Network?  Yes  No  
4. Benefits for Following Services:  
Naturopathic: % Covered \_\_\_\_\_ Co-pay/ Co-Insurance \_\_\_\_\_ Year Max \_\_\_\_\_  
Acupuncture: % Covered \_\_\_\_\_ Co-pay/ Co-Insurance \_\_\_\_\_ Year Max \_\_\_\_\_  
Number of “Modalities” Covered Per Treatment: \_\_\_\_\_  
Number of “Units” Per Modality: \_\_\_\_\_  
Extended Visit: 99354  Yes  No  
Exercise Therapy: 99112  Yes  No  
Diagnosis Coverage or Limitations: \_\_\_\_\_  
5. Co-pay per Visit or per Specialty? \_\_\_\_\_  
6. Deductible \$ \_\_\_\_\_ Amount of Deductible met so far \$ \_\_\_\_\_ Date \_\_\_\_\_  
7. Name of Representative Spoken with \_\_\_\_\_ Date \_\_\_\_\_