New England
Naturopathic Health
Corrie Marinaro, Naturopathic Doctor
Anna Froman, Naturopathic Doctor

phone: (207) 873-9380
fax: (207) 352-5217
157 Silver Street
Waterville, Maine 04901
www.naturopathicme.com
info@naturopathicme.com

Pediatric Intake Paperwork

Today's Date: _____

Child's Legal Name: _____ Birth Sex: _____ Preferred Pronoun: _____

Legal Guardian's Full Legal Name: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Home Phone: _____ Preferred Method of Contact: _____

Child's Date of Birth: _____ Child's Social Security Number: _____

Your occupation: _____ Your employer: _____

Whom to contact in case of emergency? (Please list relation and best contact number)

_____

Personal Medical History

Please list complaints for your child in order of priority:

_____

_____

_____

Please list any allergies and reactions to medicines or foods your child has:

_____

_____

Please list pharmaceutical medicines your child takes, along with the dose:

_____

Please list any health supplements (name and brands) your child takes, along with the dose:

_____

Please list any major illnesses, accidents or hospitalizations your child has experienced including dates:

_____

_____

_____

_____

Preferred pharmacy (name and address): _____

Child's pediatrician (name and address): _____

Date of your child's last physical exam: _____

Any abnormal results? _____

Date of you child's last blood work: _____

Any abnormal results? _____

Please bring last 2 years of labs with you to initial visit or have them faxed to our office in advance.

Family Medical History

Do any members of your child's immediate family suffer from any of the following health conditions? Please list which family member.

☐ Heart Disease/High Cholesterol

☐ Diabetes

☐ High Blood Pressure

☐ Cancer, Type?

☐ Alcoholism/Drug Addiction

☐ Mental Health Disorder, Type?

☐ Any other serious health conditions?

Does your child have any problems with any of the following body systems?

☐ EENT (head, ears, eyes, nose, throat)

☐ Endocrine (thyroid or another hormone imbalance)

☐ Nervous system (dizziness, imbalance, slow thinking, poor memory)

☐ Respiratory (allergies, asthma, chronic cough)

☐ Skin (psoriasis, eczema, acne)

☐ Cardiovascular (heart palpitations, chest pains, colds hands and feet, varicose veins)

☐ Digestive (GERD, heartburn, nausea, constipation, diarrhea, gas, bloating)

☐ Musculoskeletal (chronic back or limb pain)

☐ Psychological (anxiety, depression)

Lifestyle

Please provide examples of typical meals:

Breakfast	
Lunch	
Dinner	
Snacks	

How much water does your child drink in a day? _____

Does your child exercise? Please list types and amount per week:

_____

_____

Are there any problems with sleep? How many hours does your child typically sleep in a night?

_____

Please list your health goals for your child in order of priority:

Terms of Consent for Care

I, _____, hereby authorize Dr. Marinaro/Dr. Froman to perform the following specific procedures as necessary to facilitate my child's diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiology, laboratory, X-ray, paps

Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: plant substances may be prescribed as teas, alcohol-based tinctures, glycerites, capsules, tablets, creams or suppositories

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals

Craniosacral Therapy, Visceral Manipulation: gentle forms of bodywork used to address back pain and other musculoskeletal complaints, headaches and organ dysfunction

Counseling: utilization of mental health counseling and techniques

Medical use of Ozone Therapy: therapeutic ozone gas administered to isolated parts of the body, combined with depuration in an ozone sauna and injected subcutaneously or intramuscularly to address chronic pain and infections

I recognize the potential risk and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Please notify Dr. Marinaro/ Dr. Froman if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by physician, or any personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of seven years, but no more than ten years after the last day of my visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

I understand that all sales of goods and services are final. Refunds for supplements up to 90 days after purchase (unopened items only).

Signature of Legal Guardian: _____ Date: _____

New England Naturopathic Health Policies

Please initial in the following boxes:

☐ I understand that payment of consultation fees, lab fees, supplements and any other services are due at the time of service.

☐ I understand that phone consultations and phone lab reviews with Dr. Marinaro/Dr. Froman will be billed at the same rate as an in-office visit.

☐ I understand that I may message Dr. Marinaro's/Dr. Froman's support staff through Charm. Email is not an acceptable communication format due to confidentiality concerns.

☐ I understand that any supplements purchased at NENH or via Fullscript/Wellerate (per NENH request) cannot be returned once opened.

☐ I understand that if I am more than ten minutes late for an appointment. I may not be seen and may be assessed a cancellation fee.

☐ I understand that should I miss an appointment or cancel with less than a twenty-four hours' notice, I will be assessed a cancellation fee.

☐ I understand it is my responsibility to ensure insurance coverage for both office visits and labs ordered by a Naturopathic Doctor. Please refer to the Insurance Benefits Verification form for additional information.

☐ I understand that Naturopathic doctors in the state of Maine serve as specialists and not primary care doctors. For this reason, I understand that it is my responsibility to have a PCP, or to be actively looking to establish care with a PCP, prior to establishing care at New England Naturopathic Health.

☐ Patients must be seen at a minimum of once annually to maintain their place in the practice; patients who have active prescriptions through NENH must be seen every 6 months to maintain the prescription.