☙ 21st CENTURY NATURAL MEDICINE, PLLC ❧

Dr. Einat Arian, ND, PhD

9500 Roosevelt Way NE, Suite 200A; Seattle, Washington 98115

(206) 832-7650; drarian@gentlehealingarts.com

HEALTH HISTORY

Baby's Name:_____ Birthdate: _____Date:_____/_____/_____

BABY CHIEF COMPLAINTS: **Please list (in order of importance) your baby's health concerns, symptoms, or problems:**

1. _____

2. _____

3. _____

MOM'S CHIEF COMPLAINTS: **Please list (in order of importance) your health concerns, symptoms, or problems:**

1. _____

2. _____

3. _____

Baby's Gender M / F Place of Birth: _____ Height _____ Weight _____

LIST ALL MEDIATIONS / SUPPLEMENTS BABY IS CURRENTLY TAKING (doses)

ALLERGIES (foods, drugs, environmental, other)

Describe how breast feeding is going:

_____

_____

Describe how bottle feeding is going:

_____

_____

Is weight gain an issue for baby? □ no □ yes

Is baby head shape normal? □ no □ yes

Are you in pain with feeding? □ no □ yes

Rate your pain level between 0-10, 10 being worst _____

List all serious illnesses, operations, and other hospitalizations baby has had:

_____

_____

IS YOUR BABY EXPERIENCING ANY OF THE FOLLOWING? (with breast or bottle)

	Recent	Past		Recent	Past
Difficulty latching	☐	☐	Weight loss	☐	☐
Shallow latch	☐	☐	Slow weight gain	☐	☐
Losing suction	☐	☐	High palate	☐	☐
Not opening wide	☐	☐	Fussy	☐	☐
Getting frustrated	☐	☐	Gassy	☐	☐
Clicking	☐	☐	Frequent hiccups	☐	☐
Gulping	☐	☐	Frequent spit ups	☐	☐
Gagging	☐	☐	Choking/Coughing	☐	☐

Details / other issues? _____

_____

Has your baby experienced any of the following?

	Past Week	Ever		Past Week	Ever
Meconium aspiration	☐	☐	Abdominal pain	☐	☐
Fever	☐	☐	Excessive spit up	☐	☐
Hypoglycemia	☐	☐	Diarrhea	☐	☐
NICU stay	☐	☐	Breath odor	☐	☐
Birth injuries	☐	☐	Colic	☐	☐
Cerebral palsy	☐	☐	Reflux / GERD	☐	☐
High hematocrit	☐	☐	Feeding tube	☐	☐
Seizures	☐	☐	Jaundice	☐	☐
Medications	☐	☐	Phototherapy?	☐	☐
Specify:			Nasal congestion	☐	☐
Heart murmur	☐	☐	Readmitted to hospital	☐	☐
Heart defect	☐	☐	Circumcision	☐ Yes	☐ No
Blue baby	☐	☐	Lethargy	☐	☐
Explain:			Other:		

_____ _____

Guardian/Representative's Signature Date of Birth

_____ _____

Relationship to Patient/Representative Authority Date

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PATIENT INFORMATION FORM

Please put baby's info:

Last Name: _____ First Name: _____ Middle Name: _____

Address _____ City _____ State _____ Zip code_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____ Email_____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes (specify): **Home Work Cell**

Date of Birth (required) _____/_____/_____ Gender _____

Employer/School _____

Minors Only: Mother's Name: _____ Father's Name: ___ _____

Emergency Contact Name: _____ Contact's Phone: (_____) _____

Relationship to Emergency Contact _____

Do you have special needs? _____ Are you visually impaired? Yes No Hearing impaired? Yes No

In this section fill out Insurance / Card Holder's Information

Please put subscriber's information (primary card holder) here:

Insured Last Name _____ Insured First Name _____ Insured Middle Initial _____

Insurance Company _____ ID# _____ Group # _____

Insurance POBox _____ City _____ State _____ Zip _____

Insurance Phone (_____) _____ Insured Date of Birth (required) ____/_____/_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that I am responsible for all charges. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

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INFORMED CONSENT FOR TREATMENT

Name_____ **Date of Birth**_____

I hereby authorize Dr. Einat Arian, ND to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Physical Medicine**: naturopathic osseous manipulation and soft tissue work, including CranioSacral Therapy
- **Common diagnostic procedures**: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.
- **Minor office procedures**: e.g., dressing a wound, ear cleansing.
- **Medicinal use of nutrition**: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
- **Botanical medicine**: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.
- **Homeopathic medicine**: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene**: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- **Psychological Counseling**
- **Prescription medications:** may be prescribed as necessary

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

Potential risks: all interventions carry potential risks, including but not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures, possible interaction between natural supplements or products prescribed and prescription drugs.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its 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.

Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Einat Arian 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 three, but no more than ten years after the date of my last 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 Dr. Einat Arian.

_____

Signature of Patient

_____

Signature of Patient Representative or Guardian

_____

Date

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NOTICE OF PRIVACY POLICES

ACKNOWLEDGEMENT

Dr. Einat Arian and **21st Century Natural Medicine** are required to provide you with a copy of their Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at this clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please contact Dr. Arian at 21st Century Natural Medicine in the address, email, or phone number above.

I hereby acknowledge that I have received a copy of Dr. Einat Arian of 21st Century Natural Medicine Notice of Privacy Practices.

_____ _____
Patient's Name Date of Birth

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature Date

_____
Relationship to Patient/Representative Authority