



Julie Lachman, ND • 196 W. Ashland St. • Doylestown, PA 18901
• phone: (267) 895-1733 fax (888) 972-5592

Children’s Intake: 0-12 years of age

First Name: _____ Last Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: (____) _____ (cell/home/work?) Personal messages ok? __Y/ __N__

Alt. Phone: (____) _____ (cell/home/work?) Personal messages ok? __Y/ __N__

Sex (m/f): _____ Age: _____ Date of Birth: ____ / ____ / ____ Grade of School: _____

Mother’s Name and Occupation, if any: _____

Father’s Name and Occupation, if any: _____

Parents are (circle): Married Separated Divorced Living Together Other

Referred by: _____

Email Address: _____

Emergency contact person _____ Relationship _____

Pediatrician name and city located in: _____

Last time you had blood work done and with what physician: _____

Is your child currently receiving healthcare? Yes / No If yes, where and from whom?

If no, when and where did he/she last receive medical or health care?

What was the reason?

Please list your child’s most important health concerns in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Does your child have any known contagious diseases at this time? Yes / No If yes, what?

Are you coming for any specific therapy (i.e. homeopathy, nutritional counseling, botanicals, “anything that works”)? _____

Julie Lachman, ND LLC 2016 Office Policies

Client Name: _____ Date: _____

- All items must be paid for upon receipt. If you are a teleconsult patient, your items will be shipped upon receipt of payment. A shipping charge applies. Initial _____
- Refunds/Returns: returns on unopened, unused products will be accepted within 30 days with receipt. There are no refunds on opened products, custom formulae, or refrigerated products. Initial _____
- Fee for services is due upon receipt, unless prior discussion for extenuating circumstances has occurred. Fees for services rendered via teleconsult are the same as for in-office visits and are due via credit card upon completion of the visit, unless prior arrangements have been made. Initial _____
- There is no charge for your brief phone call that is scheduled after becoming a new patient or if there is a significant change in recommendations. This is a scheduled 10-minute phone call-in. Other calls lasting longer than 10 minutes will be charged the brief consult fee of \$45. Initial _____

2016 Appointment Policies

- **48 business hours advance notice is required** when rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. As receptionist do not have access to the doctor's email account, all scheduling is done via **phone** (not email) Initial: _____
- Patient concerns are handled via phone. Please **call** the office directly with any questions. No call is too small. Initial: _____
- If weather or other circumstances such as car trouble do not allow us to come to the office, phone or Skype consults may replace your in-person visit at your regularly-scheduled time, if you request. If you cancel due to weather instead of using a phone consultation, the regular cancellation fee applies. Dr. Lachman can help you set up an account if you don't have one, or you can go to www.skype.com. This ensures you will get the care you need in a timely manner should there be a weather event. _____
- It is the office policy to charge in full for missed appointments. These charges will be your responsibility and billed directly to you or charged to your credit card (below): Initial _____
- Notice of 48 hours is required when rescheduling to avoid the \$35 cancellation fee. If you reschedule to another time within the next 2 weeks, this fee will be waived. Initial _____
Payments may be made via cash, check, charge, or Health Savings Account. However, a credit or debit card is required on file should either of the above circumstances occur and we would need to charge your card. This does not apply for emergencies or extenuating circumstances.
MasterCard/Visa/Discover number: _____ Exp: _____ CCV: _____
I authorize this card to be used should there be an untimely cancellation (<48hrs) or should I fail to show up for my appointment. _____ Date: _____
- Appointment times have been arranged specifically for you. If you arrive late your session will be shortened in order to accommodate others whose appointments follow yours. If you are late, **please call in at your appointment time to get your visit started on the phone**. Initial: _____
I look forward to being of service to you/your family.

Signature of client or parent/guardian: _____

CONTEXT OF CARE OVERVIEW

1. Why did you choose to bring your child to this clinic?

What do you know about Dr. Lachman's approach?

2. What long-term expectations do you have from working with our clinic?

What three expectations do you have from your first full visit to our clinic? At the end of our hour you expect to:

- i.
- ii.
- iii

What expectations do you have of me personally as your clinician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your child's health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits for your child: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols which the doctor will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Please Note When & Why Your child has had each of the following:

X-Rays: _____ MRI/Cat Scans: _____
Ultrasounds: _____ Accidents: _____
TB Test: _____ Last bloodwork: _____
HIV: _____ Last Dental Visit: _____
Last Eye Exam: _____

List all Prescription Medicines (*including dosage*)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all Supplements and Vitamins (*including dosage in milligrams or I.U.s*)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Does your child have any allergies to (please list):
FOOD _____ DRUGS _____ MSG _____

Did you know Naturopathic medicine can help with acute cases of: ear infections, colds, the 'flu, diarrhea, ect? ___ Yes ___ No

I would be interested in having my child supported naturally for the above conditions, schedule-permitting (Monday-Friday) ___ Yes ___ No

Medications: Now Past Number of times

Aspirin _____

Tylenol _____

Decongestant _____

Ibuprofen _____

Antihistamine _____

Antibiotics _____

Medical History

Childhood Illnesses:

_____ Chicken Pox

_____ Pneumonia

_____ Measles

_____ Frequent colds

_____ Mumps

_____ Rheumatic fever

_____ Rubella

_____ Tonsillitis # of times _____

_____ Scarlet fever

_____ Ear infections # of times _____

Other: _____

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram	_____		
Psychological evaluation	_____		
Hearing	_____		
Speech / Language	_____		
Vision	_____		

Injuries / Surgeries / Hospitalizations: _____

Immunizations

_____ Polio

_____ DPT

_____ MMR

_____ Tetanus

_____ HIB

_____ Chickenpox

_____ Hepatitis B

Other: _____

Any vaccination reactions or illnesses: _____

Family History

_____ Heart disease

_____ Hypoglycemia

_____ Tuberculosis

_____ Allergies

_____ Diabetes

_____ Hypertension

_____ Hepatitis

_____ Mental illness

_____ Birth defects

_____ Arthritis

_____ Cancer

Pregnancies by birth mother _____

Miscarriages or complications _____

Mother's age at childbirth _____

Mother's health during pregnancy:

_____ Bleeding

_____ Nausea

_____ Illness

_____ High blood pressure

_____ Physical or emotional trauma

_____ Cigarettes, alcohol, drug consumption

_____ Thyroid problems

_____ Diabetes

Birth History

Term: Full _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Has your child had any of the following problems:

_____ Jaundice _____ Birth defects

_____ Colic _____ Cerebral palsy

_____ Blue baby _____ Birth injuries

_____ Diarrhea _____ Rashes

_____ Fever _____ Allergies

_____ Seizures _____ Other

Child's sleep patterns (first year) _____

Feeding: Breast fed _____ how long _____ Formula: milk / soy / other

Age began solid foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ First words _____

Diet

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Were you aware that homeopathic and naturopathic care has helped children with ‘flu, cough, colds, ear infections stomachaches, rashes, and other acute conditions? ___ Yes ___ No

Review of Systems

Now	Past		Now	Past		Now	Past	
_____	_____	Hives	_____	_____	Cough	_____	_____	Joint pains
_____	_____	Eczema	_____	_____	Hearing loss	_____	_____	Flat feet
_____	_____	Acne	_____	_____	Stomach aches	_____	_____	Muscle/bone pain
_____	_____	Chronic rash	_____	_____	Constipation	_____	_____	Dizzy spells
_____	_____	Jaundice	_____	_____	Excessive fatigue	_____	_____	Diarrhea
_____	_____	Bleeding gums	_____	_____	Gas, colic	_____	_____	Hair loss
_____	_____	Canker sores	_____	_____	Lack of appetite	_____	_____	Body/breath odor
_____	_____	Teeth problems	_____	_____	Vomiting spells	_____	_____	Cries easily
_____	_____	Nose bleeds	_____	_____	Burning urination	_____	_____	Unusual fears
_____	_____	Frequent colds	_____	_____	Bloody urine	_____	_____	Nervousness
_____	_____	Sore throats	_____	_____	Heart murmur	_____	_____	Sleep problems
_____	_____	Hay fever	_____	_____	Runny nose	_____	_____	Anemia
_____	_____	Night sweats	_____	_____	Frequent headaches	_____	_____	Nightmares
_____	_____	Easy bruising	_____	_____	Bleeding tendency	_____	_____	Wheezing
_____	_____	Motion sickness	_____	_____	Sensitive to light			

Welcome! I am honored to be of service for you and your child

Julie Lachman, ND LLC *196 W. Ashland St.* *Doylestown, PA 18901* *267-895-1733*

Your Name: _____ Date: _____

Informed Consent and Additional Information about Dr. Lachman’s services:

- Dr. Lachman graduated from a 4-year Naturopathic Medical program at an accredited Naturopathic Medical School, Southwest College of Naturopathic Medicine in Arizona. Dr. Lachman is a primary care physician licensed in the state of Vermont. As Pennsylvania does not have regulations licensing Naturopathic physicians, the practice of naturopathic medicine is therefore unregulated. Dr. Lachman is not licensed, in this state, to diagnose or treat any medical condition. If you seek the care of Dr. Lachman in Pennsylvania, she advises you to seek the concurrent care of a health care provider licensed in the state of Pennsylvania.

Initial _____

- Due to the current lack of regulation of naturopathic doctors in Pennsylvania, insurance companies are not at liberty to cover naturopathic services. Submitting information to your insurance company is unlikely to benefit you. However Health Savings Accounts (HSAs) may be used at this office. Flexible spending accounts cannot be used because they require medical necessity, which Julie cannot provide in PA.

Initial _____

- Email is useful for sending files. For privacy and in order to ensure a timely response, please *call* the office with any health-related concerns.

Initial_____

- If you notice what you believe to be an adverse effect from one of the components of your health plan, you should discontinue it then call Dr. Lachman and inform her of what occurred. Effective management of these symptoms will facilitate your healing process.

Initial_____

- Treatment with other physicians or healthcare providers are not necessarily to be discontinued. Consult the physician who prescribed your medications before discontinuing medications.

Initial_____

- Refunds>Returns: returns on unopened, unused products will be accepted within 30 days. There are no refunds on opened products, custom formulae, or refrigerated products.

Initial_____

It is the office policy to charge in full for missed appointments. These charges will be your responsibility and billed directly to you or charged to your credit card (below): Initial_____ Payments may be made via cash, check, charge, or Health Savings Account. However, a credit or debit card is required on file should either of the above circumstances occur and we would need to charge your card. This does not apply for emergencies or extenuating circumstances.

MasterCard/Visa/Discover number:_____Exp:_____

CCV:_____

I authorize this card to be used should there be an untimely cancellation (<48hrs) or should I fail to show up for my appointment._____

Date:_____

- Signature for above items on this page:_____