



Jennifer V. Rabinovich, N.D.
Doctor of Naturopathic Medicine

1657 E. Layton Rd.
 Freeland, WA 98249
 Tel: 360.331.2464
 Fax: 866.277.7173

... bringing you the gold standard of natural medical care.

www.whidbeydoctor.com

PEDIATRIC PATIENT PROFILE

I. Patient Information

Name of child (first, middle, last): _____

Child goes by: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Home phone: () _____ May we call & leave messages at this number? Yes/No (circle)

Birth date: _____ Sex: Male Female (circle)

With whom does the child live? Mom and Dad together Mom Dad Other

Who has legal custody? Mom and Dad together Mom Dad Other

Who is responsible party? Mom and Dad together Mom Dad Other

School: _____

Who referred you to us? _____

Who are the child's health care providers? _____

Would you like Dr. Rabinovich to act as your child's primary care physician? (circle): Yes No

II. Parental Information

Mother's Information:

Name: _____

Maiden Name: _____

DOB: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone #: _____

Employer: _____

Occupation: _____

Work Phone #: _____

Father's Information:

Name: _____

DOB: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone #: _____

Employer: _____

Occupation: _____

Work Phone #: _____

III. Who to Contact in Case of Emergency- Someone not in the home

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Mobile: _____

IV. Responsible Party

Who is responsible for this account? _____ Relationship to child: _____

Responsible Party Home Phone: _____ Work Phone: _____ Mobile: _____

I understand that I am financially responsible for all charges. I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Dr. Rabinovich.

 Responsible Party Signature

 Date

V. Family History

Relation	Date of Birth	Ht.	Wt.	State of Health
Father				
Mother				
Siblings				

Check if your child's *blood relatives* had any of the following (*incl. parents, siblings, grandparents, aunts, uncles*):

Check	Disease	Relationship	Check	Disease	Relationship
	Alcoholism			Heart Disease	
	Arthritis			High Blood Pressure	
	Asthma/Allergies/Hives			Hip Disorders at Birth	
	Autoimmune Disease			HIV/AIDS	
	Birth Defects			Kidney Disease	
	Bleeding Tendencies			Lazy Eye	
	Cancer			Mental Problems	
	Chemical Dependency			Strokes	
	High Cholesterol			Obesity	
	Depression			Suicide	
	Diabetes			Thyroid Disease	
	Emotional Problems			Tuberculosis	
	Epilepsy/Convulsions			Other:	
	Gastrointestinal Disease				

VI. Social History

Marital status of parents: _____

Has there been a separation, divorce or death? Specify: _____

What has been the attitude of your child to this situation: _____

Is there a gun in your home? Yes__ No__

Are there pets in your home? Yes__ No__

Does anyone in your home smoke? Yes__ No__

Are there financial problems in the family? Yes__ No__

Are there family disagreements on how to raise the child? Yes__ No__

VII. Pregnancy History With This Child

Has the mother had breast surgery? Yes__ No__

Did the mother take hormones during pregnancy? Yes__ No__

Did the mother take any drugs during pregnancy? Yes__ No__

Did anyone in the home smoke during the pregnancy? Yes__ No__

Did the mother drink any alcoholic beverages during the pregnancy? Yes__ No__

Has the mother had any miscarriages, still births, or terminations? Yes__ No__

Was the child the product of artificial insemination or a donor egg? Yes__ No__

VII. Birth History of Child

Circle one: Full term pregnancy Premature birth at _____ weeks Adopted at _____ (age)

Place of birth: _____ Type of delivery: _____

Problems at birth? (*specify*) _____

Circle: Breast fed Bottle fed Apgars: _____ Abnormal ultrasound during pregnancy: _____

VIII. Child's Development

Please list age when the following milestones were reached:

Sat alone at _____ mos. Walked at _____ mos. Words at _____ mos. Sentences at _____ mos.
First teeth at _____ mos. Bladder trained at _____ mos. Bowel trained at _____ mos.
Any handicaps? _____ Bed-wetting? _____ Family history of bed-wetting? _____

IX. School Performance (if over 6 yrs of age)

Scholastic performance: Academic _____
Behavior _____

Has child ever been in a special education class? __Yes __No Has the child had a learning challenge? _____
If yes, what type of learning challenge? _____

X. Past Illnesses

Please mark date or frequency of illness or specify substance causing allergy:

Chicken Pox _____ Ear infections _____ Allergy to medication _____
Tonsillitis _____ Urinary infections _____ Allergy to Foods _____
Pneumonia _____ Heart Murmur _____ Has child received allergy shots? _____
Convulsions _____ RSV _____ Other _____
Asthma _____ Eye Problem _____
Bronchitis/Wheezing _____

XI. Operations and Hospitalizations

Please state date and reason for all hospitalizations:

XII. What is the reason for your visit today?

Physicians most recently consulted regarding chief complaint(s):

Please list symptoms in order of importance:

Severity (1=least, 10= most severe)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

XIII. Medications and Allergies

Medications and supplements your child is currently taking, including dosage, frequency, and how long taken:

Pharmacy Name _____ Pharmacy Phone Number _____

ALLERGIES to medications or substances: _____

XIV. Anything Else?

Is there anything else about your child you feel we need to know in order to provide the best care? _____

XV. Signature

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Rabinovich or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Consent for Treatment

I hereby authorize **DR. JENNIFER RABINOVICH** to perform and/or order procedures that include but may not be limited to the following in order to facilitate my diagnosis and treatment:

General Diagnostic Procedures- including but not limited to pap smears, X-rays, blood and urine laboratory evaluation, allergy testing, infrared thermography studies, and general physical exams.

Psychological Counseling, Lifestyle Counseling, and Exercise Prescriptions

Herbs, Natural, and Allopathic Medicines- prescribing of various therapeutic substances including plant remedies, vitamins and minerals, amino acids, glandulars, and pharmaceutical drugs. Substances may be given in the form of teas, pills, powders, and tinctures that may contain alcohol; topical creams, essential oils, homeopathic remedies, flower essences, and suppositories; other medicines may also be used.

Dietary Advice and Therapeutic Nutrition- use of foods, dietary suggestions or nutritional supplements for treatment.

Soft Tissue and Osseous Manipulation- including but not limited to the use of massage, muscle energy stretching, Cranial Therapy, visceral manipulation, as well as manipulation of the spine and extremities by hand or with an activator-type device.

Thermal and Hydrotherapies- including but not limited to ultrasound, hydrocollator packs, microcurrent therapy, colonic hydrotherapy, hot and cold immersions or topical applications.

Vitamin and other Injections

Potential benefits of treatment: Restoration of health and the restoration of optimal function, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential risks of any medical treatment: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Notice to pregnant and breastfeeding patients: All patients who know or suspect that they are pregnant and/or breastfeeding must alert Dr. Rabinovich, since some of the therapies used could present a risk to the pregnancy and/or breastfeeding infant. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment. Some therapies are also contraindicated for breastfeeding women.

Agreement

Dr. Rabinovich does her utmost to ensure that you receive the most effective care. Because of the quality of the care she tries to give her patients, she can only schedule a limited number of patients each day. In consideration of this, she requests that you show up for your appointments on time. If you need to cancel an appointment, please give her 24 hours' notice. Without the 24 hours' notice, there will be a \$50 charge for missed appointments. This will be strictly enforced.

Dr. Rabinovich specializes in specific therapeutic modalities and patterns of illness, presented in more detail in the above section. Her treatment suggestions **should be considered recommendations along with conventional treatments.**

Patient Acknowledgement

I have read and understand the above statement regarding possible treatments and was given the opportunity to have any questions concerning my care answered by Dr. Rabinovich.

I am aware that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Rabinovich.

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 me or by my representative or otherwise permitted or required by law; however, by signing this form I authorize the release of my confidential health information to other participating providers directly involved in my healthcare.

I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

I certify to the best of my knowledge that the above information is correct.

I have read, understood, and agree to the terms outlined in this document.

I hereby consent to Naturopathic treatment for myself or my child/dependent.

I understand that I will pay for the services provided by Dr. Rabinovich and her staff at the time of my appointment, either in full, or according to a payment plan discussed with Dr. Rabinovich prior to the appointment.

I understand that Dr. Rabinovich requires 24 hours' notice (not including weekends and holidays) if I need to cancel or reschedule an appointment. There will be a \$50 charge for appointments cancelled or rescheduled with less than 24 hours' notice.

I am not here in my function as a government agent.

I understand that Dr. Rabinovich does not offer services during times other than regular business hours.

I have read the **Patient Orientation and Office Policies** handout for Dr. Rabinovich's services. By signing below I am in agreement with these policies.

Signed: _____ Date: _____

Print name: _____

Relationship: Self / Parent / Guardian (*circle*)