



MAINE NATURAL MEDICINE

Empowering Health™

Pediatric Intake Form (1 of 4)

Child's Name _____ Date _____

Parents: _____

Address _____

Cell Phone: _____ Work Phone _____ Email _____

Date of Birth _____ Siblings/Ages: _____

Whom to contact in case of emergency? _____

Please list health, developmental and behavioral concerns for your child in order of priority: _____

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

List 3 desired outcomes from your first visit.

1. _____

2. _____

3. _____

MARLY SACHSMAN, ND, MA-CCC

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Pediatric Intake Form (2 of 4)

Please list any allergies to medicine or foods _____

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

Please list any health supplements your child takes, along with the dose:

Personal history: Please list any major illnesses, accidents or hospitalizations your child has had including dates: (This may also be completed in a timeline format on page 4 of this intake.) _____

Who is your Pediatrician? _____

Date of your child's last visit: _____

Any abnormal results? Please provide a copy of the results.

Date of your child's last blood work: _____

Any abnormal results? Please provide a copy of the results.

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Pediatric Intake Form (3 of 4)

Family Medical History: Do any member of your child's immediate family suffer from any of the following (please indicated relation, i.e.: mother, father, sister, brother, grandmother, grandfather, aunt, uncle)

- Heart Disease/High Cholesterol:
- Diabetes:
- High Blood Pressure:
- Cancer (Type?):
- Alcoholism/Drug Addiction:
- Mental Health Disorder (Type?):
- Any other serious health disorder:

Does your child have any symptoms in any of the following body systems? Please circle & explain.

- EENT: (head, ears, eyes, nose, throat)
- Nervous system: (dizziness, imbalance, slow thinking, poor memory)
- Respiratory: (allergies, asthma, chronic cough)
- Cardiovascular: (sensation of "skipped" heartbeats or racing heart, cold hands and feet, parts of body swelling or turning blue)
- Digestive: (GERD, heartburn, nausea, constipation, diarrhea, gas, bloating)
- Musculoskeletal: (chronic back or limb pain)
- Psychological: (anxiety, depression, difficulty focusing on tasks)

What foods does your child crave? _____

Describe the kinds of activities and exercises your child participates in, and how often: _____

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Pediatric Intake Form (4 of 4)

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

Please note anything else that you believe is important to your child's health that you would like to share in the space below.

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Terms of Consent for Care

I, _____, hereby authorize Dr Sachsman to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

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

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

Integrated Awareness, Visceral Manipulation: gentle energetic forms of bodywork used to address pain musculoskeletal complaints, headaches, organ dysfunction and emotional balancing

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 Sachsman's office if your child experiences 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.

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 my child. 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 child's medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my child's medical record will be kept for a minimum of three, but no more than ten years after the last day of my visit. I understand that information from my child's medical record may be analyzed for research purposes, and that my child's 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.

Signature of Patient

Date

Signature of Patient Representative or Guardian

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