Whole Family Wellness, Inc.
Thauna Abrin, N.D.
PO Box 28• Hardwick VT 05843
(802) 472-9355 wellness@drthauna.com

Pediatric Health History Questionnaire

Name: ____ **Today's Date:** ___________
Last First M.I.

Parents or Guardian: ____________________ ______________________ _______________
Father Mother Guardian

Date of Birth:___________ **Sex:** Male__ Female __ **Current weight**______ **Height** _______

Address:____
Street/P.O. Box City State Zip Code

Parent Telephone Number: Home _____________ Work _____________ Cell_____________

Confidential Phone Number where it is ok to leave a message ________________________

Email address: ____

Insurance ID and group # ____________________________ **PPO or HMO (please circle)**

Location of your child's medical records:

____
Dr. Office/Hospital/Clinic Street/ P.O. Box City State phone number

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What are your child's most important health concerns?

1) ___________________________ 3) ________________________________
2) ___________________________ 4)_________________________________

MEDICATIONS

Now = medications currently being taken. Past = medications taken sometime in past

	Now	Past		Now	Past
Anti-histamine			Ibuprofen		
Antibiotic			Inhaler		
Asthma medication			Topical steroids		
Aspirin			Tylenol		
Decongestant			Other		

Does your child have any allergies to foods, drugs, or other environmental allergens (cats, mold, dust)?
Yes. _____ No _____ If yes, please list.

____

Current weight ______ lb _____ oz Current height ______ inches

MEDICAL HISTORY

Please check those that are applicable.

Asthma _____ Ear infections ______ Mumps ______
Bronchitis _____ Eczema ______ Pneumonia ______
Chicken pox _____ Frequent Colds ______ Scarlet Fever ______
Croup _____ Measles _______ Tonsillitis ______
Other ___________________________________

Any known exposure to heavy metals (mercury or lead paint) or toxins (pesticides or asbestos)?

____

X-RAYS AND MEDICAL EVALUATIONS

Date Location Results

Electroencephalogram: ____
Hearing: ____
Speech/Language: ____
Psychological Evaluation:____

INJURIES, SURGERIES AND HOSPITALIZATIONS

____
____
____

IMMUNIZATIONS

Diphtheria _____ HIB _____ Mumps _____ Pneumococcal _____
DPT _____ Influenza _____ MMR _____ Tetanus _____
Hepatitis B _____ Measles _____ Polio _____ Other _____

Any adverse reactions to immunizations? Please specify.

____
____

FAMILY HISTORY

Arthritis _____ Autoimmune disease _____ Depression _____ Heart disease _____
Allergies _____ Birth defects _____ Diabetes _____ Hypertension _____
Asthma _____ Cancer _____ Eczema _____ Tuberculosis _____

BIRTH HISTORY

Born at how many weeks gestation? _________ weeks
Length of labor _________________________Weight at birth _________________
Complications, if any ____

Previous pregnancies by biological mother: ________ live births _______ miscarriages

Mother's age at child's birth: _________

Mother's health during pregnancy:

Bleeding	_____	High blood pressure	_____
Cigarette, alcohol or drug use	_____	Physical or emotional trauma	_____
Diabetes	_____	Thyroid imbalance	_____
Amalgam removal or tuna intake	____	Chemical exposure	_____

Other health concerns ____

As a baby, did your child have any of the following?

Allergies	_____	Blue baby	_____	Diarrhea	_____	Rashes	______
Birth defects	_____	Colic	_____	Fever	_____	Seizures	_____
Birth injuries	_____	Cerebral palsy	_____	Jaundice	______	Other	______

Feeding: Breast fed ____ How long? _______months/years Formula: milk or soy

Age Began: Sitting _____months Crawling _____ months Walking ______ months
First tooth ______ months Solid foods ______ months
First words ______ months

<u>SYMPTOMS</u>

Please circle: Y= a condition your child has now N= never had P=has had in past

Dizzy spells	_____	Nose bleeds	_____	Cries easily	_____
Heart murmur	_____	Body/breath odor	_____	Nervous	_____
Hair loss	_____	Constipation	_____	Nightmares	_____
Night sweats	_____	Diarrhea	_____	Unusual fears	_____
Headaches	_____	Gas	_____	Bone/joint pain	_____
Hearing loss	_____	No appetite	_____	Flat feet	_____
Sore throats	_____	Stomach aches	_____	Acne	_____
Sensitive to light	_____	Vomiting spells	_____	Chronic rash	_____
Motion/car sick	_____	Canker sores	_____	Eczema	_____
Sleep problems	_____	Excessive fatigue	_____	Hives	_____
Anemia	_____	Frequent colds	_____	Bloody urine	_____
Bleeding gums	_____	High fever	_____	Burning of urine	_____
Bleeding tendency	_____	Cough	_____	Frequent urination	_____
Easy bruising	_____	Wheezing	_____	Other	_________________

<u>DIET</u>

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Anything else I should know about your child?

Whole Family Wellness, Inc.

Dr Thauna Abrin, ND • PO Box 28• Hardwick VT 05843
Phone (802) 472-9355 Fax (855) 823-0800

Office and Financial Policies

Dear New Patient,

Welcome to Whole Family Wellness. We look forward to facilitating your health journey. We encourage your questions and participation in all aspects of your health care.

Please note our office and financial policies below and sign/initial to signify your acceptance. Feel free to ask any questions about this information.

Appointments and availability

_____ Office hours are Mon 9:30-12:30, 2-5, Tues & Thurs 10-12:30, 2-5:30, Fri 9:30-12:30, 2-3 .
Office visits are by appointment only. Please call 24 hours in advance to arrange to pick up your supplements.

For questions or concerns, Dr. Abrin is available via telephone from 1-2 pm or 5-5:30 pm Monday & Thursday. The first visit includes a complementary telephone consultation. For current patients, there is no charge for brief consultations (<5 minutes).

Longer consultations > 10 min will be billed to your insurance plan. Patients without insurance will be billed at the rate of $3.00/minute. The fee is due via credit card at completion of the phone appointment (for calls longer than 7 minutes).

Dr. Abrin is available for urgent calls after hours (6 pm Monday-Friday) or weekends at her home number. In the case of an emergency at any time, please go to the nearest emergency room.

**For new patients, a copy of your current insurance card must be available for the first visit.
If your card is not available, your visit will be rescheduled.**

Patients who do not show-up to their appointment cannot be rescheduled for 1 month.

Patients who no-show or cancel (at the last minute) 2 confirmed appointments within a 12-month period will be referred to another medical provider.

FEE SCHEDULE

WHOLE FAMILY WELLNESS, INC. FEE SCHEDULE

	NEW PAT VISIT COMPRE-HENSIVE	FOLLOW UP VISIT EXTENDED	FOLLOW UP VISIT INTERMED	FOLLOW UP VISIT LIMITED	FOLLO W UP VISIT BRIEF	PHYS &/OR GYN EXAM	ADMIN-ISTER INJECTION
INSURANCE	287.50	218.50	195	161	138	230	50
TIME OF SERVICE DISCOUNT	225	150	130	100	85	130	25

Payment

_____ **For any missed appointments or late cancellations (less than 24 hours), you will be charged a $65 missed appointment fee**. The exception to this is illness or bad weather. PLEASE CALL THE OFFICE (NOT EMAIL) to communicate any last minute cancellations.

A reminder call will be made to your home phone number two days in advance of your appointment. During the call, you can confirm or cancel your appointment or request rescheduling. **Please call back or email us at wellness@drthauna.com if you are unable to keep the appt.**

If you have insurance coverage, Whole Family Wellness will bill your insurance company (for patients with Blue Cross/Blue Shield VT, BCBS Federal, Cigna, MVP, Green Mountain Care, Dr Dynasaur and You First).

Charges for visits, medicinary items, and co-payments are due at the time of the visit (check, cash, MC/VISA) unless specific arrangements have been made prior to your scheduled appointment. The patient is responsible for co-payment and co-insurance, both for visits and for injections.

For patients with insurance coverage, Whole Family Wellness with submit a claim for office visits at a rate of 219.00/hour. For those patients responsible for coinsurance, Whole Family Wellness will send you a bill for the coinsurance amount after a "RA" remittance advice is received.

For patients with a high deductible insurance plan, there is a choice of either:
1) Paying Whole Family Wellness at the time of service at a discounted rate or
2) Whole Family Wellness will submit a claim to your insurance company at a rate of 219.00/ extended visit. The patient will then receive a bill for the amount that is applied to your deductible after a "RA" remittance advice has been received by Whole Family Wellness. Please note that is total amount due is higher than the time of service discount rate.

For insurance companies in which Dr Thauna Abrin is not an enrolled provider, you are responsible for payment, and we will provide you with a bill to submit directly to your insurance carrier or to transfer onto a claim form provided by your insurance carrier. We do not accept work comp or bill for claims for automobile accidents.

For patients with Medicaid as secondary insurance, we cannot bill Green Mountain Care for co-payments. The patient is responsible for the primary insurance co-payment at the time of service.

Communication

Email communication:
Please contact Dr Abrin via email for:
●Brief treatment protocal questions & supplement refills
●Prescription refills

Please call the office for:
●Appointment changes, especially appointments cancelled in less than 24 hours
●Urgent medical concerns – 5-6 min phone appt is no charge, ask for " free phone consult"
●Scheduling follow-up appointments, both acute and chronic
●Prescription refills if you have not received a response from Dr Abrin via email

Medicinary items

_____ Insurance companies do not cover the medicinary items that we prescribe and dispense.

Nutritional supplements, including herbal tinctures and homeopathic remedies, are non-refundable.

Vitamin injections are billed at the rate of $10. This out-of-pocket expense covers the vitamin itself and your co-payment. We bill insurance for administering the injection. For self-pay patients, a vitamin b12 injection is $30.

In the event that a medicinary item needs to be special ordered, it will be shipped to you directly from the supplement company, with a $5 flat rat shipping charge (for supplement orders under $50). You will receive the item via UPS within 3-6 working days.

For supplements sent from our office, there is a shipping rate of $4 for shipping and handling, with additional charges for heavier packages. We send packages out once per week (Fridays).

If you have a Health Savings Account, we can provide a list of your supplements on prescription pad to submit to your employer.

For laboratory tests performed either at a local hospital or at home and sent to a specialized lab, the patient is responsible for any laboratory test-related fees. Be sure to call both your insurance plan and/or the billing office at the local hospital to verify coverage. Whole Family Wellness can provide the CPT (test codes) and ICD-9 (diagnostic codes) you will need to make these inquiries.

____

I have read and understand the above-stated policies of Whole Family Wellness, Inc. and will comply with them in all respects.

____________________________________ ________________

Signature (parent signature if minor) Date

____

Print (your/parent name)

Whole Family Wellness, Inc.

Office of Thauna Abrin, ND

Informed Consent Form

I, _________________________**(parent's name /child's name)** hereby request and consent to receive naturopathic medical care by the above named Vermont naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the Vermont Naturopathic Physician Act, which may include but are not limited to: nutritional counseling, herbal medicine, homeopathy, nutritional supplements, hydrotherapy, IV/injectable nutrients and certain prescription medications (according to Naturopathic Physician Formulary Rules).

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reaction (hives, rash, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with the treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises (such as trouble breathing, seizure, chest pain, fever above 103.5, anaphylaxis, or injury), please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME (printed) ____________________PARENT'S NAME ___________________________

PARENT'S SIGNATURE _______________________________________ Date: __________