CHILD PATIENT PROFILE

Name _____ Date_____

Parent Name: _____

Address: _____

City: _____ State _____ Zip _____ County _____

Phone#1 _____ Phone#2 _____

Parent Email: _____

Would you like to receive our informational newsletter, including coupons & specials? ☐ ☐

Who can we thank for referring you? _____

Name of Pediatrician: _____ Date of last physical _____

****KNOWN ALLERGIES*: _____**

Age _____ Height _____ Weight _____ DOB ____/____/_____ M ☐ F ☐

List, in order of importance, your reasons for coming in:

_____

_____

List any surgeries and/or medically diagnosed diseases:

_____

List any medications (prescription/over the counter) you are currently taking:

_____

List any supplements/herbs that you are currently taking:

_____

Vaccinated? YES / NO / SOME: _____ Breastfed? YES / NO /SOME: _____

List any diseases in your family _____

Do you drink carbonated beverages? _____ Do you eat large amounts of chocolate/sweets? _____

How often do you exercise? _____ What type? _____

Do you have amalgam (silver) dental fillings? _____ How many? _____

Blood Type? _____ *Female only* - Date of last period _____

Have you ever been exposed to extreme mold for a prolonged time period? _____

Have you ever suffered from an extreme trauma? Either emotional or physical. _____

What brand of toothpaste do you use? _____ Deodorant Brand?_____

Do you have family pets? Dogs? _____ Cats? _____ Other? _____

Do you sleep with a sleep number bed, electric blanket, or heating pad? _____

Are there any high-tension power lines or transformers near your home or where you work? _____

List any foods that you currently avoid? _____

How often do you have a bowel movement? _____

Patient Name: _____ Date: _____

PLEASE GIVE A GENERAL DIET SUMMARY FOR THE LAST THREE DAYS:

	BREAKFAST	LUNCH	DINNER	SNACKS
DAY 1				
DAY 2				
DAY 3				

****

SYMPTOM SURVEY

Please rate the severity of your symptoms LEAST WORST

Brain Fog ○○○○ ○○○○ ○○○

Neck/Upper Back Pain ○○○○ ○○○○ ○○○

Joint/Muscle Pain-*Location:* _____ ○○○○ ○○○○ ○○○

Headaches/Migraines ○○○○ ○○○○ ○○○

Tingling/Numbness in Extremities ○○○○ ○○○○ ○○○

Blurry vision / Floaters ○○○○ ○○○○ ○○○

Digestive Dysfunction ○○○○ ○○○○ ○○○

☐ **Gas/Bloating** ☐ **Indigestion/Reflux** ☐ **Diarrhea/Constipation**

Insomnia / Sleep disturbance ○○○○ ○○○○ ○○○

Fatigue/Exhaustion ○○○○ ○○○○ ○○○

Anxiety ○○○○ ○○○○ ○○○

Depression ○○○○ ○○○○ ○○○

Cardiovascular issues ○○○○ ○○○○ ○○○

Sinus / Chest Congestion ○○○○ ○○○○ ○○○

Hormone/Endocrine Imbalance ○○○○ ○○○○ ○○○

Skin Rash / Irritation ○○○○ ○○○○ ○○○

Urinary tract/Kidney dysfunction ○○○○ ○○○○ ○○○

Authorization to Release Health Information

I authorize **Longevity Health Center** to disclose my child's protected past, present and future health information to the following persons or entities:

_____ _____

This health information may be used by the person I authorize for health treatment or billing/payment purposes. This authorization will remain in effect until such time as I choose to revoke the authority in writing.

⏩⏩_____

Signature of Parent for Minor Date

STATEMENT OF UNDERSTANDING

The modalities employed by **Seneca Anderson, ND, L.Ac., Alice Honican, ND, L.Ac., Anna Powers, ND, Cristina McMullen, ND and Maria Jones, ND.** are not approved for any sort of medical evaluation. Bio-energetic evaluation will reveal "**disturbance signals**" for microbial and environmental pollutants. This evaluation should in no way be construed as a medical diagnosis. The information gathered is used to guide the recommended protocol.

I understand that none of the practitioners or the associates or staff of Longevity Health Center are medical doctors. I choose to undergo an evaluation and treatment in accordance with oriental medicinal principles, utilizing techniques of traditional and modern acupuncture.

CANCELLATION POLICY - $50 missed appointment fee

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **$50** missed appointment fee. Our goal is to provide quality health care to all our patients in a timely manner. Please be aware of our policy regarding missed appointments. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. **If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.**

If you need to cancel your appointment, please call us at **770-642-4646** between the hours of **9am to 5pm** If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

I have read and understand the above CANCELATION POLICY.
I have read and understand this STATEMENT OF UNDERSTANDING.

⏩⏩_____

Signature of Patient (or Parent of Minor) Date