Lorraine Caron, ND

1918 S. Lemay Ave., Ste. A ● Fort Collins, CO 80525 ● (970) 232-8447

Pediatric New Patient Health History

Naturopathic doctors care for the whole person, primarily by finding patterns in each person's story. Thank you for taking the time to fill out this form as completely as possible before your visit.

Patient's name: _____ Date: _____

Address: _____

City: _____ State:_____ Zip: _____

Telephone (home):_____ (parent's work):_____

Parent's e-mail address:_____

Parents, how would you prefer to be contacted? home work email

May we leave a message? home work email

Age: _____ Date of birth: _____ Gender: F M

Parent's name: _____

Occupation:_____ Daytime telephone: _____

Parent's name: _____

Occupation:_____ Daytime telephone: _____

Parents are: Married _____ Divorced _____ Separated _____ Single _____

With whom does your child live? _____

Child's school/daycare: _____

Emergency contact:_____

Relationship:_____ Phone:_____

Name of current pediatric provider: _____

Pediatric provider's contact information: _____

May we contact your child's pediatric provider to attempt to collaborate care: Yes No (Please circle one)

When was your child's last visit to the doctor's office? What was the reason? _____

_____

Is your child under the care of a medical specialist? If yes, please explain. _____

_____

Is the child currently under the care of any other health practitioners? _____

Has he/she seen a naturopathic doctor before? _____ When? _____

Parents, how did you hear about Dr. Caron? _____

*Would you like to be listed as a supporter of naturopathic medicine for our ongoing legislative effort? Checking "yes" gives Dr. Caron permission to sign you up for the CoAND's legislative alert email list. Yes_____ No_____

What are your child's most important health concerns?

1) _____

2) _____

3) _____

4) _____

What are your goals pertaining to your child's health, both short- and long-term? _____

_____

_____

Allergies

Is your child allergic or hypersensitive to any medications, foods, or environmental or chemical agents? _____

_____

Hospitalizations/surgeries/special tests

Please list any surgical procedures, hospitalizations, X-Rays, CAT scans, MRIs, EKGs, EEGs, hearing tests, vision tests, speech/language tests, or psychological evaluations your child has had: _____

_____

_____

Current medications

Please list any *prescription medications, over-the-counter medications, vitamins, or other supplements* your child takes:

_____

_____

Immunizations

MMR _____	DPT _____	Chicken pox _____	Small pox _____
Measles _____	Diphtheria _____	H. influenza _____	Hepatitis B _____
Mumps _____	Rubella _____	Tetanus _____	Polio _____
Pertussis_____	Other _____		Adverse reactions? Yes / No

Family History (please circle any that apply)

Alcoholism	Allergies	Anemia	Arthritis	Asthma
Birth defects	Cancer	Diabetes	Eczema	Epilepsy
Heart disease	Hearing loss	High blood pressure	Hypoglycemia	Mental illness
Obesity	Stroke	Thyroid disorder	Tuberculosis	

Other: _____

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Child's Health History (please check any that apply)

NOW	PAST		NOW	PAST	
_____	_____	Acne	_____	_____	Hearing loss
_____	_____	Allergies	_____	_____	Heart murmur
_____	_____	Anemia	_____	_____	High fever
_____	_____	Asthma	_____	_____	Hives
_____	_____	Bed wetting	_____	_____	Hyperactivity
_____	_____	Birth defects	_____	_____	Insomnia
_____	_____	Bleeding gums	_____	_____	Jaundice
_____	_____	Chicken pox	_____	_____	Joint pains
_____	_____	Chronic rashes	_____	_____	Learning disorder
_____	_____	Colic	_____	_____	Measles
_____	_____	Constipation	_____	_____	Mononucleosis
_____	_____	Cough/Wheeze	_____	_____	Moodiness
_____	_____	Cradle cap	_____	_____	Mumps
_____	_____	Croup	_____	_____	Nightmares
_____	_____	Depression	_____	_____	Nosebleeds
_____	_____	Diarrhea	_____	_____	Pneumonia
_____	_____	Dizzy spells	_____	_____	Rheumatic fever
_____	_____	Earaches	_____	_____	Rubella
_____	_____	Ear infections	_____	_____	Scarlet fever
_____	_____	Easy bruising	_____	_____	Stomachaches
_____	_____	Eczema	_____	_____	Strep throat
_____	_____	Epilepsy/seizures	_____	_____	Stuffy nose
_____	_____	Fatigue	_____	_____	Thrush
_____	_____	Flat feet	_____	_____	Tonsillitis
_____	_____	Frequent colds	_____	_____	Urinary tract infections
_____	_____	Frequent headaches	_____	_____	Vomiting spells
_____	_____	Frequent urination	_____	_____	Whooping cough
_____	_____	Hair loss	_____	_____	Other: _____
_____	_____	Headaches			

Prenatal/Birth/Feeding History

Please answer questions regarding the mother's health during her pregnancy with this child.

Age at child's birth: _____ Trauma/injury _____ Alcohol consumption _____

Bleeding _____ Stress _____ Drug use _____

Nausea _____ High blood pressure _____ Smoking _____

Illness _____ X-rays _____ Diabetes _____

Toxemia _____ Medications _____ Thyroid problems _____

Other _____

TERM: Full _____ Premature _____ Late _____ Birth weight: _____

Length of labor: _____ Was birth… Easy _____ Moderate _____ Difficult _____

Any complications? _____

Place of birth: Hospital _____ Home _____ Clinic _____ Other _____

FEEDING: Breast fed? _____ How long? _____

Formula? _____ How long? _____ What kind? _____

Age solid foods introduced: _____

Favorite foods: _____

Food intolerances: _____

Please describe your child's typical daily diet

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

drinks: _____

Developmental / School Concerns

Slow development (sitting, walking, talking): _____

School difficulties (learning, attention): _____

Safety

Is there any old / peeling paint inside or outside the home? _____

Is your child exposed to any toxic chemical in your home or at your work? _____

Is there a working fire alarm on each floor of your house? _____

Are there any firearms in your home? _____

If so, are they securely locked? _____

Is your child always buckled into a securely fastened car seat or seat belt while riding in a car? _____

Does your child wear a helmet while bike riding, skateboarding, skiing, etc? _____

Are there any smokers in the home or childcare setting? _____

Please list the names, ages, and any health problems of the child's siblings

_____

_____

Please include any other information about your child that you would like to share

_____

_____

_____

_____

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DISCLOSURE STATEMENT

Lorraine Caron, ND was trained in naturopathic medicine at the National College of Naturopathic Medicine (NCNM) in Portland, Oregon. She received her ND (Naturopathic Doctor) degree in 2004, after four years of post-graduate clinical and academic training.

Dr. Caron holds an active ND license in the state of Oregon as well as an active registration in the state of Colorado. The Oregon Board of Naturopathic Examiners (OBNE) is the regulatory board for all naturopathic physicians licensed in Oregon. No license or certification issued to Dr. Caron has ever been revoked or suspended.

OBNE
800 NE Oregon St., Suite 407
Portland, OR 97232
(503) 731-4045

Office of Naturopathic Doctor Registration
(303) 894-7414
http://www.dora.state.co.us/reg_investigations/file_complaint.htm

Naturopathic Doctors are registered by the state of Colorado to practice naturopathic medicine under the "Naturopathic Doctor Act." They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device. Certain in-office procedures are permitted.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Treat a child who is less than two years old, unless (1) a collaborative agreement with a pediatrician or family practice physician is on file with DORA, (2)) this form is fully completed and signed; (3) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (4) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one.
- Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one.
- Practice medicine, surgery, obstetrics, or any other form of healing other than Naturopathic Medicine.
- Perform chiropractic services (spinal adjustments, manipulation, or mobilization). Physical medicine, as described in § 12-37.3-102(12)(b), C.R.S., is permitted.
- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

In the professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the OBNE or to the Director of Naturopathic Doctor Registration using the contact information above.

The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another health care professional or may terminate therapy at any time.

Consultations are payable at the time of the visit. Any additional services, laboratory tests, or medicinary products are individually priced. A fee schedule is available upon request.

_____ _____

Patient Name Parent Name

_____ _____

Signature of patient or parent/guardian Date

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's name _____

Birthdate_____

Parent/guardian's name _____

Signature of parent/guardian _____

Date_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on August 1st, 2006 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization**. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

***Notification*:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims* of *Abuse, Neglect, or Domestic Violence*:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

***Workers Compensation*:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities*:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

NOTICE OF PRIVACY PRACTICES

***Law Enforcement**:* Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

***Appointment Reminders**:* We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

***Alternative and Additional Medical Services**:* We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

YOUR INDIVIDUAL RIGHTS

***You Have* a *Right to**:*

1. Look at or get copies of certain parts of your medical information. You must make your request in writing using a medical release form obtained from the clinic. You may also request your records by sending a letter to the doctor who provided your care. If you request copies, we will charge you $0.15 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to your doctor at this clinic.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have that right.

QUESTIONS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights.

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.