Lachman and Associates ● 1432 Easton Rd, Suite 3G ● Warrington, PA 18976
● P: 267-406-0782 ● F: 888-972-5592

Children's Intake: 0-12 years of age

First Name: _____Last Name:_____ Date:_____

Address: _____

City: _____State: _____ Zip: _____

Preferred phone: (____)_____(cell/home/work?) Personal messages ok? __Y/___N__
Alt. Phone: (_____)_____(cell/home/work?) Personal messages ok? __Y/___N__
Sex (m/f): _____ Age: _____ Date of Birth: ____/____/____ Grade of School: _____
Mother's Name and Occupation, if any: _____
Father's Name and Occupation, if any: _____
Parents are (circle): Married Separated Divorced Living Together Other
Referred by: _____
Email Address: _____

Emergency contact person_____Relationship_____
Pediatrician name and city located in: _____
Last time you had blood work done and with what physician: _____
_____
Is your child currently receiving healthcare? Yes / No If yes, where and from whom?
_____
If no, when and where did he/she last receive medical or health care?
_____
What was the reason?
_____
Please list your child's most important health concerns in order of importance:
1) _____
2) _____
3) _____
4) _____
5) _____

Does your child have any known contagious diseases at this time? Yes / No If yes, what?
_____
Are you coming for any specific therapy (i.e. homeopathy, nutritional counseling, botanicals, "anything that works")?
_____

Office Policies
Client Name: _____ Date:_____

• All items must be paid for upon receipt. If you are a teleconsult patient, your items will be shipped upon receipt of payment. A shipping charge applies. Initial: _____
• Fee for services is due upon receipt, unless prior discussion for extenuating circumstances has occurred. Fees for services rendered via teleconsult are the same as for in-office visits and are due via credit card upon completion of the visit, unless prior arrangements have been made. Initial: _____
• Acute calls, like for cold, fever, UTI, etc, range in price from $75-$125, depending on how long you speak with the doctor (5 - 30 minutes). Initial: _____

Appointment Policies
• If weather or other circumstances such as car trouble do not allow us to come to the office, phone or tele-consults may replace your in-person visit at your regularly-scheduled time, if you request. This ensures you will get the care you need in a timely manner should there be a weather event. Initial: _____
• Appointment times have been arranged specifically for you. If you are late, ***please call in*** *at your appointment time to get your visit started on the phone*. Initial: _____
• I understand that my intake visit is in 3 parts: the intake visit, the results visit and a therapeutic assessment. I understand that one fee of $695 covers both visits and any time for the doctor to study the case outside of our visits. Initial: _____

- There are no refunds on this payment, regardless of the number of visits you attend. Initial: _____

I look forward to being of service to you/your family.

Signature of client or parent/guardian:_____

CONTEXT OF CARE OVERVIEW

1. Why did you choose to bring your child to this clinic?

What do you know about our approach?

2. a) What long-term expectations do you have from working with our clinic?

b) What three expectations do you have from your first full visit to our clinic? At the end of our hour you expect to:

i.
ii.
iii.

c) What expectations do you have of me personally as your clinician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your child's health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits for your child: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols which the doctor will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Please Note When & Why Your child has had each of the following:

X-Rays: _____ MRI/Cat Scans: _____

Ultrasounds: _____ Accidents: _____

TB Test: _____ Last blood work: _____

HIV: _____ Last Dental Visit: _____

Last Eye Exam: _____

List all Prescription Medicines (*including dosage) and date they began taking them (month/year)*

_____ _____

_____ _____

_____ _____

_____ _____

List all Supplements and Vitamins (*including dosage in milligrams or I.U.s) and the date they began taking them (month/year)*

_____ _____

_____ _____

_____ _____

Does your child have any allergies to (please list):

FOOD _____DRUGS_____MSG_____

CURRENT HEIGHT (inches) & WEIGHT(lbs): _____

Did you know Naturopathic medicine can help with acute cases of: ear infections, colds, the 'flu, diarrhea, ect? ____Yes_____No

I would be interested in having my child supported naturally for the above conditions, schedule-permitting (Monday-Friday)_____Yes_____No

Medications:	Now	Past	Number of times
Aspirin	____	____	____
Tylenol	____	____	____
Decongestant	____	____	____
Ibuprofen	____	____	____
Antihistamine	____	____	____
Antibiotics	____	____	____

MEDICAL HISTORY

Childhood Illnesses:

_____ Chicken Pox

_____ Measles

_____ Mumps

_____ Rubella

_____ Scarlet fever

_____ Pneumonia

_____ Frequent colds

_____ Rheumatic fever

_____ Tonsillitis # of times_____

_____ Ear infections # of times_____

Other:_____

Has your child had any of the following tests?

	When	Where	Results
Electroencephalogram			
Psychological evaluation			
Hearing			
Speech / Language			
Vision			

Injuries / Surgeries / Hospitalizations: _____

IMMUNIZATIONS

_____ Polio

_____ MMR

_____ HIB

_____Hepatitis B

_____ DPT 6

_____ Tetanus

_____ Chickenpox

Other: _____

Any vaccination reactions or illnesses:_____

FAMILY HISTORY

_____ Heart disease

_____ Hypoglycemia

_____ Tuberculosis

_____ Allergies

_____ Diabetes

_____ Hypertension

_____ Hepatitis

_____ Mental illness

_____ Birth defects

_____ Arthritis

_____ Cancer

Pregnancies by birth mother _____

Miscarriages or complications _____

Mother's age at childbirth _____

Mother's health during pregnancy:

_____ Bleeding

_____ Physical or emotional trauma

_____ Nausea

_____ Illness

_____ High blood pressure

_____ Cigarettes, alcohol, drug consumption

_____ Thyroid problems

_____ Diabetes

BIRTH HISTORY

Term: Full _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Has your child had any of the following problems:

_____ Jaundice

_____ Colic

_____ Blue baby

_____ Diarrhea

_____ Fever

_____ Seizures

_____ Birth defects

_____ Cerebral palsy

_____ Birth injuries

_____ Rashes

_____ Allergies

_____ Other

Child's sleep patterns (first year) _____

Feeding: Breast fed _____ how long _____ Formula: milk / soy / other

Age began solid foods: _____ Formula brand: _____

Age began: Sitting _____ Crawling _____ Walking _____ First words _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Were you aware that homeopathic and naturopathic care has helped children with 'flu, cough, colds, ear infections stomachaches, rashes, and other acute conditions?____Yes____No

Review of Systems Now Past

Now Past			Now Past			Now Past	
_____	____	Hives	____	____	Cough	____	____ Joint pains
_____	____	Eczema	____	____	Hearing loss	____	____ Flat feet
____	____	Acne	____	____	Stomach aches	____	____ Muscle/bone pain
____	____	Chronic rash	____	____	Constipation	____	____ Dizzy spells
____	____	Jaundice	____	____	Excessive fatigue	____	____ Diarrhea
____	____	Bleeding gums	____	____	Gas, colic	____	____ Hair loss
____	____	Canker sores	____	____	Lack of appetite	____	____ Body/breath odor
____	____	Teeth problems	____	____	Vomiting spells	____	____ Cries easily
____	____	Nose bleeds	____	____	Burning urination	____	____ Unusual fears
____	____	Frequent colds	____	____	Bloody urine	____	____ Nervousness
____	____	Sore throats	____	____	Heart murmur	____	____ Sleep problems
____	____	Hay fever	____	____	Runny nose	____	____ Anemia
____	____	Night sweats	____	____	Frequent headaches	____	____ Nightmares
____	____	Easy bruising	____	____	Bleeding tendency	____	____ Wheezing
____	____	Motion sickness	____	____	Sensitive to light	____	____ Bed wetting
						____	____ Pacifier use

Welcome! We are honored to be of service for you and your child!

Julie Lachman, ND ● 1432 Easton Rd, Suite 3G ● Warrington, PA 18976 ● P: 267-406-0782 ● F: 888-972-5592

Your Name:_____Date:_____

Informed Consent and Additional Information about Dr. Lachman's services:

• Our doctors graduated from a 4-year Naturopathic Medical program at an accredited Naturopathic Medical School, Southwest College of Naturopathic Medicine in Arizona. Dr. Lachman is a primary care physician licensed in the state of Vermont. As Pennsylvania does not have regulations licensing Naturopathic physicians, the practice of naturopathic medicine is therefore unregulated. Dr. Lachman is not licensed, in this state, to diagnose or treat any medical condition. If you seek the care of Dr. Lachman in Pennsylvania, she advises you to seek the concurrent care of a health care provider licensed in the state of Pennsylvania.
Initial:_____

• Due to the current lack of regulation of naturopathic doctors in Pennsylvania, insurance companies are not at liberty to cover naturopathic services. Submitting information to your insurance company is unlikely to benefit you. However Health Savings Accounts (HSAs) may be used at this office. Flexible spending accounts cannot be used because they require medical necessity, which Julie cannot provide in PA.
Initial:_____

• Email is useful for sending files. For privacy and in order to ensure a timely response, please *call* the office with any health-related concerns.
Initial:_____

- If you notice what you believe to be an adverse effect from one of the components of your health plan, you should discontinue it then call the office and inform us of what occurred. Effective

management of these symptoms will facilitate your healing process.
Initial:_____

• Treatment with other physicians or healthcare providers are not necessarily to be discontinued. Consult the physician who prescribed your medications before discontinuing medications.
Initial:_____

- Refunds/Returns: returns on unopened, unused products will be accepted within 30 days. There are no refunds on opened products, custom formulae, or refrigerated products.
Initial:_____

It is the office policy to charge in full for missed appointments. These charges will be your responsibility and billed directly to you or charged to your credit card (below):
Initial:_____

Payments may be made via cash, check, charge, or Health Savings Account. However, a credit or debit card is required on file should either of the above circumstances occur and we would need to charge your card. This does not apply for emergencies or extenuating circumstances.

MasterCard/Visa/Discover number:_____

Exp:_____ CCV:_____

I authorize this card to be used should there be an untimely cancellation (<48hrs) or should I fail to show up for my appointment.

_____Date:_____

• Signature for above items on this page:_____