



Dr. Julia Gonen, N.D.
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CHILD INTAKE FORM

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will help to provide me with a general overview of your child's health on a physical, mental, and emotional level, and assist me in preparing a treatment plan that will best meet their individual health needs and goals.

Full Name _____ Date _____
 Date of Birth _____ (d/m/y) Age _____ Sex: M F

Who is filling out this form? (Name & Relation) _____

Name of parent(s)/guardian(s): _____

Address:	Phone: _____ (h)
	_____ (w)
	_____ (mobile)

Email: _____

How can we best reach you? _____

May we leave messages pertaining to your child's visits: Y N

Is the child yours by: Birth Adoption Stepchild Other: _____

Are parents: Married Unmarried Remarried Widowed Separated Divorced

Who does the child live with? _____

Child's primary care Physician/Paediatrician: _____

How did you hear about our office? _____

How would you rate your child's current state of health: Excellent Good Fair Poor

Please list child's health concerns in order of importance (yours and theirs):

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL HISTORY:

Please describe any serious conditions, hospitalizations, operations, illnesses or injuries with their dates:

Please list all current medications the child is taking (ie. prescription, over-the-counter, etc.):

Please list all vitamins, herbs, homeopathics or other supplements the child is taking:



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Please list any medication your child has taken for an extended period of time:

How many times has your child been on antibiotics? 0 - 2 3 - 5 5 or more

Does your child have any allergies (environmental, medicines, seasonal, etc.)? Describe:

Please indicate if your child has recently been tested for the following?

Hearing Yes No Vision Yes No Yearly physical Yes No
 Dental Yes No Speech Yes No Blood tests Yes No

Please circle if your child had any of the following conditions currently (C) or in the past (P) (you may circle both):

Strep Throat	C	P	Asthma	C	P	Hives/Rashes	C	P
Chicken pox	C	P	Bronchitis	C	P	Eczema	C	P
Measles	C	P	Allergies	C	P	Herpes (oral)	C	P
Rubella (German Measles)	C	P	Itchy eyes	C	P	Bruises easily	C	P
Mononucleosis	C	P	Chronic colds	C	P	Bad breath	C	P
Mumps	C	P	Sinus troubles	C	P	Fainting	C	P
Roseola	C	P	Ear infections	C	P	Seizures	C	P
Whooping cough	C	P	Recurring fevers	C	P	Headaches	C	P
Influenza	C	P	Constipation	C	P	Temper tantrums	C	P
Scarlet Fever	C	P	Diarrhea	C	P	Bed wetting	C	P
Impetigo	C	P	Digestive problems	C	P	Nail biting	C	P
Pneumonia	C	P	Colic	C	P	Depression/Anxiety	C	P
Other: _____								

IMMUNIZATIONS:

Has your child received regular vaccinations according to the standard Paediatric schedule?

Yes No, explain: _____

If known, please indicate which of the following vaccinations your child has had:

- DPT (diphtheria, pertussis, tetanus) Tetanus booster MMR (measles, mumps, rubella)
 HiB (Haemophilus influenza B) Polio "chicken pox"
 Hepatitis A Hepatitis B "flu shot"
 Meningitis HPV
 Other: _____

Has your child had any adverse reaction to a vaccination? Please explain.



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FAMILY HISTORY:

	Any medical conditions?	Are they still living?	If not, what was cause of death?	Age
Mother				
Maternal Grandmother				
Maternal Grandfather				
Father				
Paternal Grandmother				
Paternal Grandfather				
Siblings:				

PERINATAL HISTORY:

What was the health of the parents at conception?

- Mother Poor Fair Good Excellent Unknown
 Father Poor Fair Good Excellent Unknown

What was the mother's health during pregnancy?

- Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy?

- Poor Fair Good Excellent Unknown

Describe any particular food cravings during the pregnancy: _____

Was this a planned pregnancy? Yes No

What was the mother's age at the child's birth? _____ father's age at birth? _____

Any genetic concerns? Describe: _____

Where there any fertility issues? Describe: _____

Did the mother receive prenatal medical care? Yes No Unknown

Did the mother experience any of the following during the pregnancy?

- Emotional stress Nausea Vomiting High blood pressure Diabetes
 Placenta previa Toxemia Bleeding Thyroid problems Ultrasounds
 Physical trauma Exposure to cigarette smoke
 Other: _____



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Did the mother use any of the following during the pregnancy?

- Tobacco Alcohol Recreational drugs: _____
- Prescription medications: _____
- Over-the-counter medications: _____
- Supplements: _____
- Other: _____

BIRTH HISTORY:

Term Length: Premature: _____ wks Early: _____ wks Full-term Late: _____ wks

Birth weight: _____ Birth length: _____ APGAR score: 1min _____ 5min _____

Delivery by: Vaginal birth Cesarean, why? _____

Check if any of the following interventions apply to the birth?

- Forceps Vacuum extraction External fetal monitor Epidural Pitocin
- Induction of labour Other: _____

Where there any complications during/after delivery? _____

Did the child experience any of the following at or shortly after birth?

- Jaundice Rashes Seizures Birth injuries: _____
- Birth defects: _____
- Other: _____

Please indicate any medical problems during baby's newborn/infancy period: _____

NUTRITION & DIET:

Was your child breastfed? No Yes, for how long? _____

If formula was introduced, when? _____ What type? _____

When were solid foods introduced? _____

Which foods were introduced first? _____

Any reactions? _____

Please list any food allergies or intolerances:

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Does your child have any food aversions? If so, to which foods? _____



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Is your child a "picky" eater? Please explain. _____

Has your child had any unusual feeding/dietary issues or habits?

Milk intake now:

Cow milk (Non-fat 1% 2% Whole milk) Soy milk Rice milk Other: _____

How often does your child:

Drink soda pop? More than once/day Once/day Sometimes Never
 Have caffeine? More than once/day Once/day Sometimes Never
 Eat chocolate? More than once/day Once/day Sometimes Never

Please describe a typical day's diet:

Breakfast	Lunch	Dinner	Snacks	Beverages (including amounts)

SLEEP:

Does your child sleep through the night? Yes No Occasionally

Hours per night _____ Naps (number & length) _____

Any sleeping problems? _____

DEVELOPMENT:

Child's weight: _____ Child's height: _____

At what age did your child:

Sit alone _____ Crawl _____ Walk alone _____ Say words _____ Toilet train _____

LIFESTYLE / ENVIRONMENT:

Is the child presently in: School Daycare Homecare Other: _____

What are your child's favorite activities/interests? _____

Is your child exposed to cigarette smoke? Yes No

Do you have pets: No Yes, _____



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Do you know of any environmental toxins / hazards (chemicals, fumes, dust, etc.) your child is regularly exposed to?

How often does your child:

ACTIVITY	Never	1 - 4 hrs/wk	4 - 8 hrs/wk	More than 8 hrs/wk
Watch TV/videos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play videogames	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read (or is read to)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____				

Please describe your child's temperament / behaviour, as best as you can:

Please describe any fears / anxieties / worries your child has:

Please describe your child's behaviour and performance at school:

If over 4 years old, does your child have a "best" friend? Yes No

Are there any concerns about relationships with:

- Teachers: No Yes, _____
- Peers: No Yes, _____
- Siblings: No Yes, _____
- Other: _____

Does your child have any learning difficulties? Describe:

How would you describe the emotional climate of the child's home?

Is there any other relevant information you would like to discuss that has not been covered?



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ADOLESCENT INTAKE FORM

At what age did you experience the onset of puberty? _____

How would you rate your current state of health? Excellent Good Fair Poor

Are you satisfied with your current weight? Yes No

Have you ever done any of the following to lose weight:
 skipped meals, taken pills, vomited, taken laxatives or herbal supplements? Yes No

Are you satisfied with your appearance? Yes No

Are you satisfied about your relationship with your family? Yes No

Are you satisfied about your relationship with your peers? Yes No

Are you (or have you been) sexually active? Yes No

 If yes, do you practice "safe-sex"? Yes No

 Have you ever had unprotected sex? Yes No

Have you ever been in a relationship in which you have felt threatened or unsafe? Yes No

Do you ever consume alcoholic beverages? Yes No

If yes, how much and how often? _____

Do you smoke cigarettes? Yes No

If yes, how much and how often? _____

Are you using any recreational drugs? (marijuana, ecstasy, LSD, etc.)? Yes No

If yes, which ones and how often? _____

How would others describe you?

Is there anything else that you would like to discuss or get information about?

♀ FOR GIRLS ONLY

At what age was your first menstrual period? _____ Length of cycle? _____ Length of period? _____

Do you experience any of the following regarding menstruation?

- Spotting Cramping Severe pain Heavy bleeding Scanty bleeding
- PMS Depression Fluid retention Absent periods Infrequent periods
- Cravings Vomiting Moodiness Irregular periods Cyclical breast pain

If you checked PMS, please describe your symptoms:

Do you do breast self-examinations? Yes No

Are you currently taking a Birth Control Pill? No Yes, which one? _____

If yes, what is the reason? _____



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I am aware that the Fee Schedule is as follows (as of October 1, 2007):

fee schedule

general fees

Initial consultation (90 minutes)	₪450
Follow-up visit (60 minutes)	₪290
Follow-up visit (30 minutes)	₪160

children (16 and under) & students (with valid id)

Initial consultation (60-90 minutes)	₪320
Follow-up visit (45-60 minutes)	₪250
Follow-up visit (30 minutes)	₪140

facial rejuvenation acupuncture

Initial consultation (90 minutes)	₪450
Single treatment (60 minutes)	₪390
Package of 12 treatments	₪3900

HypnoBirthing®

5 classes (2.5 hours each)	₪1500
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Urinalysis

₪10

I am aware that Julia Gonen, N.D., is not a medical doctor, and her services are not covered by your Kupat Cholim.

I am aware that there is a 24-hour cancellation policy. Missed appointments without 24 hours notice of cancellation will be subject to a ₪120.00 missed appointment fee.

I am also aware that at this time, payments may only be made by cash or cheque.

By signing this declaration, I acknowledge that I have read the above, and that I agree to pay all costs incurred for treatment at the time of visit.

Name _____

Signature _____

Date _____



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INFORMED CONSENT

This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's natural ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. Assessment of each patient's physical, mental, emotional and spiritual well-being is required to facilitate this work. If you are working with a Naturopathic Doctor, a physical exam and specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Therapies used by a Naturopathic Doctor may include: Clinical Nutrition, Botanical Medicine, Homeopathy, Traditional Asian Medicine & Acupuncture, Lifestyle Counseling & Stress Management, Hydrotherapy, and Physical Medicine including massage and soft tissue manipulation.

Statement of Acknowledgement

I, (print your name) _____, acknowledge that as a patient of this clinic I have read the information included herein, and understand that the form of medical care is based on Naturopathic Medicine and other supportive principles and practices. I also recognize that even the gentlest therapies have potential complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, or those on multiple medications. I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and / or supplements I am currently taking (prescription and over-the-counter), or was previously taking. If female, I have advised my practitioner of any chance that I am pregnant or lactating, and will continue to do so.

Despite the low incidence, there are some slight risks to some Naturopathic treatments. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture intramuscular injections or acupuncture
- muscle strains and sprains, disc injuries from spinal manipulations.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.

I understand that the treatment and therapies rendered or recommended to me by my Naturopathic Doctor, may be different than those usually offered by a medical doctor or other licensed health care providers.



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I understand that any treatment or advice provided to me by my Naturopathic Doctor is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; which I agree to disclose to my Naturopathic Doctor.

I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in the State of Israel.

I understand that my Naturopathic Doctor has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider.

I understand that my practitioner will answer any questions I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above except:

(patient's signature & date)

I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment. As the patient, I am responsible for the total charges incurred for each visit, and have been informed of the fee schedule and accepted methods of payment.

(parent or guardian's signature & date)

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment I receive under the care of Julia Gonen, N.D. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, regional, state or government agency attempting to gather information without so stating.

(parent or guaridan's signature)

(date)

(witness' signature)

(date)

(signature Julia Gonen, N.D. lic#1480)

(date)