Michelle Crowder, ND
427 W University Dr, Rochester MI 48306

New Patient – Pediatric

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations.

This is a CONFIDENTIAL questionnaire. Date of Initial Visit: _____

First Name: _____Middle Name: _____Last Name: _____

How should we address your child? _____Mother's name: _____ Father's name: _____

Address:_____City: _____State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/_____ Age: _____

Place of Birth: _____ city/state/country

Mobile Phone :(_____) _____-_____ Home Phone: (_____) _____-_____

Best number to call: _____May we leave a message? Y or N Email address_____

Birth Sex: _____ Gender identity: _____ Preferred Gender Pronouns:_____

Primary Care Physician: _____ Referred by:_____

Emergency contact: _____Relationship to patient: _____

What aspects of your child's health are most important to address at this time? Please list health concerns in order of importance.

_____

_____

_____

Name some positive elements in your child's life

_____

What 3 expectations do you have for this first visit?

1._____

2._____

3. _____

Last time your child saw a physician and reason:_____

Names of any specialists your child sees with specialty:

_____

MEDICAL HISTORY:

Birth: Full term_____ Premature_____ Vaginal delivery_____ C-Section_____

Any issues during the pregnancy or birth? _____

Breast Fed___ If so, for how long? _____ Bottle fed_____ Age of: Solid food introduction: _____ Walk: _____ Talk: _____

Previous medical diagnoses or conditions with year diagnosed: _____

_____

Surgeries with year: _____

Childhood illnesses and immunizations:

Illness	Had it	Never had it	Vaccinated	Illness	Had it	Never had it	Vaccinated
Mumps				**Pertussis**			
Measles				**Polio**			
Rubella				**Tetanus**			
Diptheria				**Hepatitis B**			
Chicken pox				**Influenza**			
Shingles				**Meningitis**			
Rheumatic Fever				**HPV**			

ALLERGIES: To any medications or foods? Yes__ No__ If yes, please list with reaction: _____

_____

ALCOHOL, TOBACCO, OR RECREACTIONAL DRUG USE:
Please describe: _____

FAMILY HEALTH HISTORY:

	Age if living	Age of death	Health problems
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			

MEDICATIONS: Current. Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SUPPLEMENTS: List all vitamins, minerals, and other nutritional supplements that your child is taking now. (Indicate mg or IU)

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PERSONAL LIFE:
With whom does your child live? _____

Current education: _____

NUTRITION:
What is your child's typical -

- **Breakfast?** _____
- **Lunch?** _____
- **Dinner?** _____
- **Snacking? If so, what and when?**_____

Is your child on a special diet? _____

Does your child have any history of disordered eating or emotional concerns related to food? If yes, please explain:

_____

Beverages consumed (water, milk, fruit juice, soda pop, etc) _____

Any use of artificial sweeteners? If so, which one(s)? _____

EXERCISE/MOVEMENT:

What types of movement does your child do and how often?_____

Does your child spend time outdoors? _____

SLEEP/RELAXATION:

How many hours of sleep per night? _____

Any concerns related to sleep? _____

How is your child's energy? _____

STRESS/GRIEF:

Any significant life changes recently? _____

Does your child's stress level interfere with enjoyment of life, sleep or relationships?_____

Is there any history of physical, emotional, or sexual abuse? _____

RELIGION/SPIRITUALITY:

Does your child engage in regular prayer or meditation? _____

LEISURE/REJEUVENATION:

What brings your child joy? _____

Interests, hobbies, extracurricular activities: _____

How do they manage their stress? _____

Review of Systems

***please select any symptoms that you have experienced in the past 7 days**

Constitutional: □fever □ difficulty managing weight □ poor appetite □ binge eating/drinking
□fatigue □ restlessness □ general weakness □ low stamina □ rapid hunger
□ no Thirst □ frequent Thirst □ food cravings if yes, please list_____

Body Temperature: □Cold □ Warm □ Neutral □ Hot

Skin/Nails: □ rash □ acne □ vitiligo □ rosacea □ eczema □ psoriasis □itching
□hives □ thin/cracking/peeling nails □ nail fungus □ discolored nails □ nails with ridges
□ nails with pits

HENT: □ hearing loss □ ringing in ears □ ear pain □ sore throat □ hoarse voice
□ clearing throat □ canker sores □ dental cavities □ Grind Teeth □ TMJ
□ gums sore/swollen □ tongue sore □ nasal congestion □ bad breath

Eyes: □itching □ watering □ redness □ drainage □ bags under eyes
□ dark circles □ change in vision □ light sensitivity □ floaters □ eyelid irritation

Cardiovascular: □chest pain □ palpitations

Respiratory: □cough □ wheezing □ difficulty breathing

Gastrointestinal: □reflux □ belching □nausea □ vomiting □ cramping
□Burning sensation □ pain □diarrhea □ constipation □ excess gas □ bloating □ hemorrhoids
□ mucus in stool □ blood in stool □ black stools □ rectal pain □ stool incontinence

□Stool pattern: How often? _____ Color? _____ Consistency? _____

Genitourinary: □frequency □ pain with urination □ up at night to urinate □ incontinence □ blood in urine
□ genital discharge □ genital itching Color of urine? _____

Females: Date of menarche_____ Last menstrual period_____ Any problems with menses? _____

Musculoskeletal: □joint pain □ joint stiffness □ muscle pain □ muscle stiffness □ neck pain
□ back pain □ muscle cramps □ muscle twitching

Endo/heme: □easy bruising □ easy bleeding □ easily over heated □ cold intolerant
□ low libido □ erectile dysfunction □ breast abnormality □ irregular periods
□ heavy periods □ frequent thirst □ sweating □ hot flashes □ hair loss

Allergy/Immune: □food allergies □ environmental allergies □ frequent infections

Neurologic: □headache □ dizziness □ numbness/tingling □ fainting □ tremor
□ memory loss □ vertigo (spinning/movement sensation) □ difficulty with balance

Psychiatric: □anxiety □depression □ hallucinations

In seeking care from Michelle Crowder, Naturopathic Doctor, I understand the following:

1. The State of Michigan does not currently regulate or license Naturopathic Physicians or the practice of Naturopathic Medicine. Therefore, Michelle Crowder, ND cannot diagnose, treat, or cure any condition. Instead, she provides health information and recommendations.

2. Michelle Crowder, ND is licensed in the State of Oregon and regulated by the Oregon Board of Naturopathic Medicine.

3. I should remain under the care of my primary care physician and will discuss any changes to my current treatment with my primary care physician.

4. My consultations with Michelle Crowder, ND are confidential and will not be disclosed except where required by law or with prior authorization.

5. Payment is due at the time of service. Signing below serves as acknowledgement that you have received and reviewed current office visit fees.

6. Because Naturopathic Physicians are not currently licensed in the state of Michigan, their services may not be covered under a Health Savings Account or Flex Spending Account. If you choose to use these methods as forms of payment, it is at your own risk.

7. If you would like to submit a claim to your insurance company for services provided by Michelle Crowder, ND, you must obtain proper documentation. Please inquire with our billing department.

8. Late and missed appointments: Please allow at least 24 hours' notice if you need to reschedule or cancel your appointment. Missed appointments are subject to the following fees: $250 for new patient visits; $90 for follow-up visits. If you are late to your appointment, your appointment time will be shortened to what remains during your originally scheduled appointment, and you will be charged for the full amount of the scheduled appointment.

9. Please use our patient portal system for communication in between appointments. Depending on the number or complexity of your questions, you may be asked to schedule an office visit so that we have ample time to discuss your concerns.

10. If you would like Michelle Crowder, ND to communicate about your care with other physicians or practitioners, please provide their contact information below:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Parent or legal guardian signature: _____ Date: _____

Printed Name: _____

Patient's Name: _____