DR. NYARAI PAWENI

p: 877.961.4417
NATUROPATHIC DOCTOR

e: drnyarai@nyaraipawenind.com
www. nyaraipawenind.com
www.facebook.com/drnyaraipaweni

Welcome Letter

I am honored that you have chosen me to help and your child in your search for optimum health and wellness. This is your **New Pediatric Patient Information Packet**. Please read and complete the attached forms prior to your appointment, bring them with you or email them to drnyarai@nyaraipawenind.com. The more detailed your responses, are the better able, I will be at investigating and determining some of the causes of your health concerns. This will also help us utilize our time together efficiently.

In order to best serve you, please bring or forward of your child's copies of any prior lab work (within the last 12 months) and a list of the supplements and medications you are currently taking with you to your appointment.

It is our office policy to confirm appointments by phone or email one to two business days before your scheduled visit. If you have an answering machine or voice mail, a message will be left.

Many of our patients are sensitive to environmental substances, therefore we ask all patients to refrain from wearing strongly scented hair sprays, colognes, perfumes, aftershaves, etc. on the days you are here.

Please call my office at (877)961.4417 or email me at drnyarai@nyaraipawenind.com with you have any questions or concerns.

Thank you! I look forward to meeting you!

Dr. Nyarai Paweni (Dr. Nyarai)

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New Patient Checklist

☐ Please return completed new pediatric patient intake packet prior to new patient appointment.

☐ Please arrive 20 minutes early to fill out intake forms if you have not sent them in prior to your appointment.

☐ Allow 60 to 90 minutes for your first visit. Note this is the same for in-person/phone/Skype visit

☐ Please be courteous and send a call 877.961.4417 if you're running late.

☐ All payments are due at the time of service. We accept cash, check, or any credit card including American Express.

Please bring to your first appointment the following items:

☐ Child's recent blood work, imaging, and/or medical records if necessary (within the last 12 months).

☐ A list of all medications your child is currently taking (including dose, frequency, and duration).

☐ Please bring the bottles (or photographs) of the supplements that your child is currently taking.

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PATIENT INTAKE FORM

Dr. Nyarai Paweni's comprehensive consultation is only possible when we have a complete picture of your child physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Print all information and mark anything you don't understand with a question mark. Please be assured that we will keep this information confidential.

Thank you for taking the time to complete this form, so we may be of greater service to you.

How did you hear about our Dr. Nyarai?_____

☐ Search engine inquiry
☐ Google maps
☐ Dr. Nyarai Paweni's website
☐ Facebook
☐ Twitter
☐ Other _____
☐ Friend/family non-patient
☐ Referred by Friend/Family current patient

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Financial Policies

The following is to assist you in understanding the financial policies associated with your care with Dr. Nyarai Paweni. Please discuss any financial concerns you have with Dr. Nyarai prior to your visit.

Payment Requirements: Appointments must be paid for at time of service. We accept Visa, MasterCard, American Express, Discover, check, cash, Travelers Checks or PayPal. You will be charged a $25 fee for returned checks.

All clients are asked to pay in full at the time of the visit. Labs, supplements, herbs, homeopathic medicines and hydrotherapy treatments are an additional fee added to the cost of the visit

Appointments: 24 hour notice is needed to change or cancel your appointment. You will be charged a fee of 50% of the total cost of any missed appointment if the 24 hour advance cancellation policy was not met.

Records: Dr. Nyarai will keep a record of your health care. A small fee is charged for copies of your medical records. Your medical record will not be disclosed to others unless you direct Dr. Nyarai to do so or unless the law authorizes her to disclose the information.

Insurance and Medicare: Dr. Nyarai Paweni does not bill insurance companies and is not a preferred provider for any insurance company. You may submit your paid invoice to your insurance for reimbursement. Please request this upon checkout if you wish to do this. Dr. Nyarai is not a Medicare provider. Medicare will not reimburse you for services rendered at the clinic and you should not seek reimbursement from Medicare.

Thank you for taking the time to complete this form. We look forward to providing you the best possible care.

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Pediatric Intake

Today's date: _____

Child's name: _____ Date of birth: _____ Gender: M F

Who is filling out this form (name and relation)?:_____

Contacts (in order of preference):

Name _____ Phone _____Cell
Address_____ _____Home
_____ _____
_____ Email _____

Relationship to child _____

Name _____ Phone _____Cell
Address_____ _____Home
_____ _____
_____ Email _____

Relationship to child _____

Other health care providers:

1._____ 2._____ 3._____

Phone: (____) _____ Phone: (____) _____ Phone: (____) _____

Email: _____ Email: _____ Email: _____

What are your child's health concerns, in order of importance:

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

Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

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Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____

_____

_____

Which of the following has your child had? (N– Never, M – Mild, A – Average, S – Severe)

N M A S Rubella (German measles)
N M A S Measles
N M A S Chicken pox
N M A S Mumps
N M A S Roseola
N M A S Scarlet Fever
N M A S Whooping Cough
N M A S Strep Throat
N M A S Impetigo
N M A S Mononucleosis
N M A S Ear Infections

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

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

How many times has your child been treated with antibiotics? ____In the past year? _____

Please indicate which immunizations your child has received:

☐DPT (diphtheria, pertussis, tetanus)
☐Tetanus booster; when? _____
☐ MMR (measles, mumps, rubella)
☐Haemophilus influenza B
☐ "Flu"
☐ Polio
☐Hepatitis B
☐ Hepatitis A

Other: _____

Please indicate any adverse reaction your child experienced in response to a vaccination:

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

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Prenatal health

How would you describe the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

How would you describe the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

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

Did the mother receive prenatal medical care? Y N Unknown

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

☐Bleeding ☐High blood pressure ☐Diabetes ☐Thyroid problems
☐ Physical or emotional trauma

Other: _____

_____

Did the mother use any of the following during the pregnancy?
☐Tobacco ☐Alcohol ☐Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐Supplements: _____
☐Other: _____

Was the mother exposed to significant second-hand smoke during pregnancy?: Y N

Birth History

Term length: ☐ Full ☐Premature: _____wks _ Late: _____wks

Length of labour: _____Weight at birth _____

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Any complications? _____

Was the birth: ☐ Vaginal/C-section ☐ Induced ☐Forceps ☐Anesthesia used

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

☐ Jaundice ☐Rashes ☐ Seizures ☐ Birth injuries_____

☐ Birth defects _____

☐ Other _____

Family History

Indicate whether a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Birth defects	
Kidney disease		Autoimmune(Lupus,RA, Thyroid diseae)	
Juvenile arthritis			
GI disorders			

☐ I don't know the family medical history of the child

Do either of the parents have a chronic illness? Y N Please describe:

_____

Diet

How was your infant fed?

☐Breast fed. How long?: _____ ☐Formula. Milk/Soy/Other: _____

☐Other: _____

What foods were introduced before 6 months? (Please list approximate month as well):

_____

_____

6–12 months?:

_____

_____

_____

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Did your child ever experience colic?: Y N How severe? Mild Moderate Severe

Does your child have any food allergies or intolerances? Please list:

_____

_____

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, gluten-free, dairy-free etc.)?:
_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (type and amount) _____

Environment
Is the child in school daycare home care other : _____

What are your child's favorite activities? _____

_____

Does the child exercise regularly? Y N Please describe the type and frequency of physical activity:
_____

_____

How much television does your child watch? _____Hrs a day/week
How much computer/tablets/cell phone? _____Hrs a day/week
How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐Weekly ☐Less than weekly

Does anyone in the child's household smoke? Y N
Are there animals in the home? Y N

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Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

_____

_____

_____

_____

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

_____

_____

How would you describe your child's temperament?

_____

How would you describe your child's behavior in school/ daycare?:

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

Please check all programs which you feel would be beneficial for your child:

☐ Detoxification Program (diet, herbs, homeopathic remedies)
☐ Prevention Program (based on familial predispositions or current risk factors)
☐ Weight Loss/ Body Composition Program
☐ Exercise Program
☐ Healthy Eating Program
☐ Stress Management Program/ Biofeedback
☐ Testing for Vitamin/Mineral Deficiencies
☐ Organic Skincare Products

Final Thoughts/Comments:

_____