



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: \_\_\_\_\_
- There is no charge for your brief phone call that may be scheduled after becoming a new patient or if there is a significant change in recommendations. Other calls range in price from \$25-70, depending on how long you speak with the doctor. 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 arrive late your session will be shortened in order to accommodate others whose appointments follow yours. 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 \$395 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 \_\_\_\_\_

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	_____ Pneumonia
_____ Measles	_____ Frequent colds
_____ Mumps	_____ Rheumatic fever
_____ Rubella	_____ Tonsillitis # of times _____
_____ Scarlet fever	_____ 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	_____ DPT 6
_____ MMR	_____ Tetanus
_____ HIB	_____ Chickenpox
_____ Hepatitis B	Other: _____

Any vaccination reactions or illnesses: \_\_\_\_\_

**FAMILY HISTORY**

_____ Heart disease	_____ Hepatitis
_____ Hypoglycemia	_____ Mental illness
_____ Tuberculosis	_____ Birth defects
_____ Allergies	_____ Arthritis
_____ Diabetes	_____ Cancer
_____ Hypertension	

# Pregnancies by birth mother \_\_\_\_\_

Miscarriages or complications \_\_\_\_\_

Mother's age at childbirth \_\_\_\_\_

Mother's health during pregnancy:

_____ Bleeding	_____ Physical or emotional trauma
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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	

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: \_\_\_\_\_