VITACORE

An AK-Based Vitalistic Wellness Center

CHILD

Confidential Patient Health History Form

Patient Information

Last Name:_____ First:_____ Middle: _____ Date:_____

Address:_____ City: _____ State: ____ Zip: _____

Phone Number:_____ (cell/home) E-mail Address:_____

Birth Date_____ Sex: Male or Female Marital Status:_____ # of Children _____

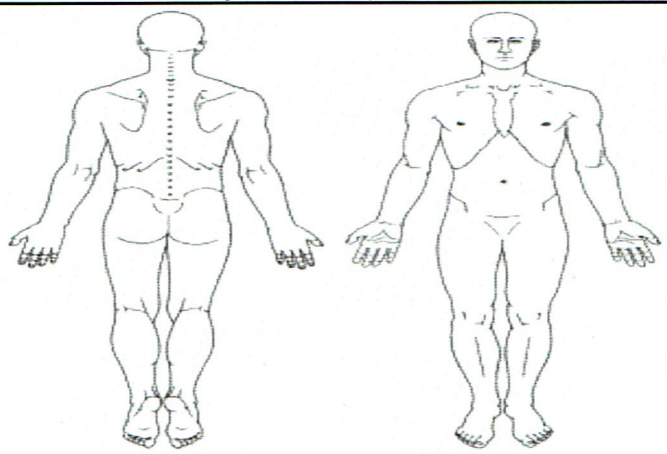
Occupation:_____ Employer:_____

Parent/Guardian (if minor):_____ How did you hear about us?:_____

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Primary Care Physician:_____ May we contact them? Yes/No Phone Number:_____

Please **circle** any areas of pain/discomfort on the graph below **AND describe** the pain in detail:



Head	
Neck	
Shoulders	
Back	
Arms	
Elbows	
Wrists	
Hands	
Hips	
Legs	
Knees	
Feet	

How long have you had this condition?_____ What seemed to be the cause?_____

How often does this issue bother you? _____ Is it getting worse? Yes / No

What **treatments** have you already received for this condition? _____

Have you seen a Chiropractor or Naturopathic Doctor for this condition? If yes, name of practitioner and when:

_____

What is your **energy level** on a scale from 0-10 (10 being highest): _____/10

Have you ever:	**Yes**	**No**	**If yes, please explain:**
Had broken bones, strains or sprains?			
Used a cane, crutch or other support?			
Been struck unconscious?			
Had major dental work? (Root canal, Extractions, Etc.)			
Had any surgeries?			

How much water do you drink daily?	What time do you generally fall asleep/wake up?
Do you have difficulty getting to sleep?	How many times do you awake in middle of night?

Put an X next to any health conditions you have experienced **in your lifetime**
Circle any you have experienced **in the past few months**

	Immunizations	Date
	Tetanus	
	Hepatitis	
	Pneumonia	
	Flu	
	COVID	

	Eye/Ear/Nose/Throat
	Vision Problems
	Hearing Loss
	Ear Ache/Infection
	Ringing/Noise in Ears
	Redness in Ears
	Nose Bleeds
	Sinus Infection/Pain/Obstruction
	Tonsilitis
	Sore Throat
	Enlarged Glands
	Hoarseness
	Thyroid Disorder

	Heart & Lungs
	Asthma
	Coughing/Wheezing
	Collapsed Lung
	Chest Pain
	Difficulty Breathing
	Heart Disease
	Poor Circulation
	Pneumonia
	Spitting Up Blood
	Spitting Up Phlegm

	Gastrointestinal
	Burping or Gas
	Constipation
	Diarrhea
	Bloated Abdomen
	Blood in Stool
	Excessive Hunger
	Gallbladder Trouble
	Intestinal Worms
	Irritable Bowel Syndrome
	Nausea
	Pain Over Stomach
	Poor Appetite
	Skipping Meals
	Ulcerative Colitis
	Vomitting/Vomit Blood

	Genitourinary
	Bladder or Kidney Infection
	Bed-wetting
	Blood in Urine
	Pus in Urine
	Discolored Urine
	Frequent or Painful Urination
	Lack of Bladder Control

	Skin
	Hives/Boils/Bumps/Rashes
	Bruises Easily
	Dryness
	Itching
	Skin Redness

	Other
	Anxiety/Nervousness
	Appendicitis
	Bloody Nose
	Chicken Pox
	Cold Hands/Feet
	Colds
	Cold Sores/Fever Blisters
	Dental Issues
	Depression
	Diabetes
	Dizziness
	Epilepsy
	Fainting
	Fatigue
	Fever
	Headaches/Migraines
	Influenza (Flu)
	Malaria
	Measles or Mumps
	Onset of Puberty
	Polio
	Numbness
	Scarlet or Rheumatic Fever
	Scoliosis/Spine Curvature
	Swelling in Arms/Legs
	Tuberculosis
	Typhoid Fever
	Weight Gain or Loss
	Whooping Cough

Please check any of the following events that you have had or still have worry over:

- □ Family Fighting
- □ Birth of Siblings
- □ Having Accidents
- □ Moving/Traveling
- □ Pets
- □ Loved One Being Sick/Having Illness
- □ Somebody they Love Passed Away
- □ School
- □ Teachers
- □ Friends
- □ Bullying
- □ A Babysitter or Other Caregiver
- □ Onset of Puberty
- □ Other: _____

On a scale from 1-10 with 10 being the most stress, please rate your child's level of stress? _____
Is there any person or place that you do not want to visit? Yes / No
Is there anything you'd like to talk to Dr. Haque about privately? Yes / No

Please list any medications, supplements or food allergies you may have:

Name	Symptoms

Please list all medications and/or supplements that you are currently taking:

Name	Dosage	Date Started	Reason	

VITA**CORE**

Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. The full length Notice is available at the front desk of all locations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting this information. As our patient, we create medical records about your health, our care for you, and services we provide to you as our patient. By law, we are required to make sure that your Protected Health Information (PHI) is kept private and confidential.

How will we use or disclose your information? Here are a few examples:

*For medical treatment
*For appointment and patient recall reminders
*To obtain payment for our services
*For research
*In emergency situations
*In response to requests arising out of a lawsuit

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

*The right to inspect and copy
*The right to request confidential communications
*The right to an accounting of disclosures
*The right to request restrictions
*The right to a paper copy of this notice
*The right to ammend

The Practice may phone, email or send a text to you to confirm appointments. We may also leave a message by voicemail on your cell phone or at your home if you have an answering machine or service, unless otherwise requested in writing.

For more information about these rights, please see the full notice posted in the office or request the detailed Notice of Privacy Practices from the front desk. This notice applies to all clinics and providers of VitaCore Holistic.

_____
Print Patient's Name

_____
Signature of Patient or Representative

_____
Print Name of Representative (if applicable)

_____
Date

I hereby grant permission to disclose my health information to the following individual(s). I may revoke permission at any time by notifying the practice in writing of my intent to do so.
Individual's Name/Relationship to Patient:
Individual's Name/Relationship to Patient:

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Informed Consent

I, _____, a mature adult of sound mind, come to S. Raheel Haque ND for Naturopathic healthcare for either myself or as a guardian of _____.

I understand that Dr. S. Raheel Haque attended and graduated from the National University of Health Sciences, a 4 year accredited Naturopathic and Chiropractic Medical school, with Doctorate of Naturopathic and Chiropractic Medicine degrees.

I understand that any herbs, nutritional supplements, essential oils, adjustments and homeopathic remedies that may be recommended are not a treatment for any health condition - rather natural substances that support my body systems. I agree to inform Dr. S. Raheel Haque immediately of any adverse reactions while I am using these substances.

I understand that should I continue to consult with my primary and specialty care physicians in regard to any medical concerns that I may have. I understand that Dr. S. Raheel Haque cannot and will not advise on the discontinuation of any pharmaceutical medications prescribed by a physician, and that discontinuation of such medications must be directed by the prescribing physician. I agree to take responsibility for following up on any referrals for medical care when necessary.

Dr. S. Raheel Haque realizes that privacy and communication with patients are very important. Dr. S. Raheel Haque will hold my records and information in strict confidentiality. However, I understand that communication modalities used in consulting with VitaCore Holistic, including but not limited to phone, email and video chat may or may not be HIPPA compliant. I accept all risks if I choose to communicate by these methods.

Dr. S. Raheel Haque recommends supplements from companies that he trusts. I understand that supplements are an unregulated industry and that the brands Dr. S. Raheel Haque uses are of a higher quality that have been clinically proven by his mentors over the years of research and practice. Therefore, if I choose to purchase supplements from other sources, Dr. S. Raheel Haque cannot place reliance on these supplements.

I understand that many interactions between herbs themselves, and between herbs and medications my physicians may prescribe, may not be well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in effect of the medications. I understand that I should inform my physicians of all supplements I am taking. I also agree to inform Dr. S. Raheel Haque of all medications and supplements I am taking.

All female patients must inform Dr. S. Raheel Haque if they know or suspect that they may be pregnant or are trying to conceive as some of the supplements used could present a risk.

For any new concern, a visit must be scheduled so that it can be properly evaluated. Email or waiting to hear back for a visit is never appropriate for urgent or emergency problems. Please go to Urgent Care or the ER for emergencies.

Signature of Patient or Guardian: _____ **Date:** _____