THE NEW LIFE CENTER
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CHILD HEALTH HISTORY FORM

Date of 1st Appointment _____

Name_____ Gender M___ F___ Birth Date _____ Age_____

Name your child likes to be called_____ Height ____ft _____ in Weight _____pounds

Address _____ City _____ State_____ Zip _____

Mother's Name _____ email address: _____

Home Phone_____Work Phone_____Mobile Phone_____

Father's Name _____ email address: _____

Home Phone_____Work Phone_____Mobile Phone_____

Who Told You About The New Life Center / Dr. Alvarado?_____

Please list what you want to achieve for your child at The New Life Center:

_____

_____

_____

What problems, difficulties, illnesses, or complaints would you like remedied?

_____

_____

_____

Has your child ever received health care or treatment from a:

☐ Naturopathic Physician ☐ Acupuncturist ☐ Other "Natural Practitioner"

Please check any that have been a problem for a parent, grand-parent, sister, brother, aunt or uncle:

☐ cancer	☐ arthritis	☐ kidney disease	☐ thyroid/adrenal
☐ diabetes	☐ stroke	☐ heart problems	☐ high blood pressure
☐ celiacs	☐ epilepsy	☐ asthma	☐ mental disorder
☐ alcoholism / addiction		☐ autoimmune or inherited _____	

Please check any of the following your child is exposed to:

☐ dust	☐ mold	☐ dampness	☐ fumes
☐ chemicals	☐ paint	☐ solvents	☐ insecticides
☐ varnishes	☐ lacquers	☐ excessive heat	☐ excessive cold

Please UNDERLINE any of the following your child has experienced in the past,

and

Please CIRCLE any which your child currently or has recently experienced:

fear	phobias	nervousness	extreme stress
extreme pain	insomnia	grief	guilt
loneliness	nightmares	irritability	low self-esteem
lack of confidence	angry outbursts	"hyper" behavior	insensitive behavior
compulsiveness	depression/disinterest	trembling	shallow breathing
cold sweats	confusion	difficult concentration	fever
asthma	allergies	skin condition	head injury
bone/joint disease	jaundice	hepatitis	mononucleosis
appendicitis	seizures	headaches	migraines
yeast problems	thrush	diabetes	cancer
broken bones	back pain	neck pain	major injury
unusual change in appetite		unusual change in weight	
food, chemical, or drug poisoning		night sweats	muscle twitching
unusual lumps	enlarged glands	abnormal discharges	abnormal bleeding
dizziness	loss of balance	abnormal sensations	eye pain
tearing eyes	ringing ears	nosebleeds	wheezing
short of breath	chest pain	irregular heart beat	swelling or edema
difficulty swallowing	stomach problems	digestive problems	mouth sores
intestinal disease	bowel problems	food intolerances	kidney problems

urinary symptoms: frequency, urgency, bed wetting, other urinary symptoms

Does your child have any other health problem or condition you wish to mention?

_____

_____

_____

_____

_____

	YES	NO
Does your child follow any special way of eating?	_____	_____

Please explain: _____

_____

_____

Are you aware of your child having any allergies?	_____	_____

Please explain: _____

_____

_____

Has your child ever been hospitalized or had surgery?	_____	_____

Please explain: _____

_____

_____

Is your child receiving care for their well-being now?	_____	_____

From whom? _____

For what purpose?_____

_____

_____

Please list all prescribed medication, over-the-counter medication, vitamin and food supplements, herbs, homeopathics and any other remedies and treatments which your child is using now. Thank You.

What is used	**What it's for**	**How much used**	**How long used**

Thank you for taking the time to complete this form. It will help me to help your child. I look forward to meeting with both of you.

Gil Alvarado, N.D., L.Ac., Dipl. Ac.

Appointments and Payment

We have found it is best to be sure that everyone is clear about appointment and payment policies before their first appointment. The policies are simple. This note is to insure your understanding. If you have any questions or concerns please call The Center and we will answer them for you.

Your child's first appointment at The Center will be about 1.5 hours. The fee is $205. Future visits will be about 3/4 hours and the fee is $105. Nutritional supplements and herbal remedies, etc. are charged separately. If for any reason you are unable to keep an appointment please give us as much notice as possible, and at least call 24 working day hours before the appointment (ie. call by 10:00 AM on Friday for a 10:00 AM Monday appointment) or you will be responsible for full payment. We regret that past experience has made this policy necessary.

Full payment is due at the time services are rendered. Should this ever not be possible, please make specific financial arrangements with us before your visit. We do not routinely send bills for services. If you have insurance that covers our services, the receipt you receive from us will have all the information your insurance company needs to reimburse you. We do not accept payment directly from insurance companies. If you have any questions please call us and we will be happy to answer them for you.

Thank you again for bringing your child to The New Life Center. I appreciate and value the privilege of serving your child and will do my best to help your child receive the assistance they need and deserve.

Please sign and date this form and email or fax it to us with your child's Health History Form. Thank you.

I have read and agree to the information and policies described above.

Name (please print) _____

Signature _____ Date _____

Relationship to child _____