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701.258.9418| 800.290.7028
www.dakotanaturalhealth.com

CHILD PATIENT INTAKE FORM

(Ages 0-12 years)

PLEASE PRINT

Date: ____ Birthdate:_____________________

Name: ____

Address: ____City: __________________________

State: ______________________ Zip Code: __________________ Sex/Gender: M / F

Parent/Guardian Name: ____

Parent/Guardian Phone # ____

Parent/Guardian Email ____

How did you hear about us? ____

*It may be valuable for Dakota Natural Health Center (DNHC) to contact you via phone, text message or email. Choose the following option (s):

( ) YES, DNHC may leave a voicemail ( ) YES, DNHC, may sent me a text message to confirm my appointment

( ) YES, DNHC, may email me. **If none selected, then no voicemail, text message or emails will be sent.

Health History Questionnaire

Primary reason(s) for today's appointment? ____

____

____

____

What types of therapy have you tried for this problem(s) (i.e. medical doctor visit, medications, diet modification, supplements, etc.)?

____

____

____

Are there any medical conditions that you have been diagnosed with? ______________________________

____

____

Current medications (include dosage and how often you take each): _______________________________

____

____

____

Current vitamins, supplements, herbs, etc.:
____
____
____

Operations or hospitalizations (please include dates): ____

____

Allergies (medications, foods, environmental): ____

____

Family History:

Asthma/Allergies	Yes / No	Anxiety	Yes / No
Autoimmune Disease	Yes / No	Depression	Yes / No
Ear, Nose, Throat problems	Yes / No	Skin Problems	Yes / No
Digestive Disorders	Yes / No	Other: ___________________________________	

Please list your other health care providers (primary care, specialists, chiropractor, etc.):

Name: Field/Specialty:

____
____
____
____

***HIPPA PRIVACY STATEMENT: An extended HIPPA Privacy Statement is available upon request to be mailed or emailed to you. In short, Dakota Natural Health Center, will not sell, give out or in any other way release your private medical or personal information without your written permission, except where required by law.**

*** I am responsible for paying all appointment fees at the time of service and for appointments I fail to cancel prior to 24 hours.**

*** I understand that the care I receive today is complementary to my existing healthcare plan. I am responsible for notifying my medical provider about the changes I choose to make.**

Your signature below indicates that you understand the above statements

____________________________________ ________________________________

(Parent/Guardian Signature) (Date)