



DR. WILES GOSS NATURAL HEALTH
Your Journey Through Health & Life

NEW PATIENT PACKET

Welcome To Our Clinic

First Visit Checklist

- Completed **intake forms**
If forms are completed before the day of your appointment, please scan and send by email to drwilesgoss@gmail.com.
- Please bring all **supplements/medications** and recent **lab work**.
- Please plan to arrive **5 minutes early**. We have a “no wait” policy. Every effort will be made to be respectful of your time by keeping on schedule.
- Upon entering the office, a receptionist will be there to greet you, please **check in** and **wait in the seating area** and I will be with you shortly.
- All payments are expected at the **time of service**. We accept cash, check, Visa, and MasterCard.
- If we accept your insurance, please bring your insurance information so that we can provide you with all the necessary information to submit to your insurance provider.

PEDIATRIC INTAKE (0-12 YRS)

Contact Info:

Patient Name: _____ Date: _____

Parent/ Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ (cell): _____

Parent's E-mail: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you hear about this clinic? _____

Demographics:

Patient's Age: _____ Date of Birth: _____ Gender: F M

Thank You For Your Time & Effort

Holistic health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Health History Questionnaire

Do the child have a primary care doctor? Y N

Name: _____ Location: _____ Phone: _____

Is the child currently under the care of any other physician/healthcare providers?

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

Name: _____ Location: _____ Phone: _____

Specialty/Reason for seeing: _____

What are your child's most important health problems? List in order of importance.

1.) _____ Onset: _____

2.) _____ Onset: _____

3.) _____ Onset: _____

4.) _____ Onset: _____

5.) _____ Onset: _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

What is your present level of commitment to address any *underlying causes* of your child's signs & symptoms? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What three expectations do you have of me personally as your health care provider?

General

Height _____ Weight _____ Maximal Weight _____ When? _____

How would you rate your child's overall health?

Excellent Good Average Fair Poor

Family History

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Previous Illnesses

Rheumatic fever	Y	N	
Chicken pox	Y	N	
Tonsillitis	Y	N	Approximate number _____
Ear infections	Y	N	Approximate number _____
Measles	Y	N	
Rubella	Y	N	
Other	_____		

of colds each year _____

Immunization History

Polio	Y	N	Pertussis	Y	N
Tetanus shot	Y	N	Diphtheria	Y	N

Measles/Mumps/Rubella	Y	N	HIB	Y	N
Flu Shot Date _____	Y	N	Hepatitis _____	Y	N
Chicken Pox	Y	N	Other _____		

Adverse reactions? Y N
 If yes, what? _____

Hospitalization, Surgery, Lab Work or Imaging (x-rays, CAT scans, MRI's, EEG, EKG)

_____ year	_____	_____ year	_____
_____ year	_____	_____ year	_____
_____ year	_____	_____ year	_____

Has your child had any of the following tests? If yes, when and where?

Psychological evaluation? _____

Hearing tests? _____

Speech/language tests? _____

Mental Health

Have the child had any times of major psychological trauma? Y N

Age: _____

Age: _____

Age: _____

Medications & Supplements

Please list any **prescriptions & over the counter medications** you take *consistently*.

Attach additional sheet if needed.

Drug: _____ Dose: _____ How long? _____

Drug: _____ Dose: _____ How long? _____

Drug: _____ Dose: _____ How long? _____

Drug: _____ Dose: _____ How long? _____

Drug: _____ Dose: _____ How long? _____

Please list any **supplements** you are currently taking. Please include the **brand name**.

_____ Dose: _____ How long? _____

_____ Dose: _____ How long? _____

_____ Dose: _____ How long? _____

_____ Dose: _____ How long? _____

_____ Dose: _____ How long? _____

_____ Dose: _____ How long? _____

Allergies & Hypersensitivities

Drugs? _____

Foods? _____

Environmental or chemical? _____

Was the child breastfed? Y N How long? _____
Did the child have formula? Y N If yes, what kind? ie. milk, soy, etc. _____

Diet

Does your child follow a certain diet? Y N
If yes, please circle.

Vegetarian Vegan Paleolithic Anti-inflammatory Blood-type Atkins
Low-fat/low calorie Gluten-free Dairy-free Other _____

What does your child typically eat for each meal?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do they drink each day? _____

Toxic Exposures

Has your child ever lived in a smoking household? Y N

Has your child ever had exposures to lead, pesticides, mercury, chemicals etc? Y N

If yes, what & when? _____

Birth History

Child's birth weight _____ lbs

Term: ___ Full ___ Premature ___ Late

Any complications with the child's birth? Y N

If yes, what? _____

Did your child have any of the following problems shortly after birth? Please circle.

Rashes Jaundice Colic Birth injuries Seizures Fever Blue baby Cerebral palsy
Birth defects Other _____

Mother's health during pregnancy:

Bleeding Y N

Illnesses Y N If yes, what? _____

Medications Y N If yes, what? _____

Nausea Y N

Hypertension Y N

Diabetes	Y	N	
Physical or emotional trauma	Y	N	
Cigarettes, alcohol, drug consumption	Y	N	If yes, what? _____
Thyroid problems	Y	N	

Mothers age at birth? _____

Symptoms Please circle all that apply.

Hives	Burning urine	Bloody urine	Eczema
Cries easily	Bleeding gums	Heart murmur	Nervous/anxiety
Nose bleeds	Vomiting spells	Sleep problems	Asthma
Acne	Anemia	Night sweats	High fevers
Jaundice	Sensitive to light	Chronic rash	Stomach aches
Diarrhea	Hearing loss	Easy bruising	Sore throats
Flat feet	No appetite	Body/breath odor	Constipation/diarrhea
Nightmares	Frequent colds	Bleeding tendency	Unusual fears
Wheezing	Joint pain	Excessive fatigue	Cough
Dizzy spells	Hair loss	Frequent urination	Allergies/runny nose
Sadness	Difficulty learning	Behavior problems	

Is there any information about your child's health that you would like us to know? Please include if this information can be discussed in front of your child.

THANK YOU! WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that *you identify* who are involved in your health care or health care bills.
- To protect the public’s health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

Please do not phone me at home. Use this alternate phone number: _____

Please do not phone me at work. Use this alternate phone number: _____

Please do not leave messages on my answering machine.

Please do not contact me by email.

Please send mail, including my bills, to this alternate address: _____

 Other request (please describe): _____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

_____/_____/_____
Date

PAYMENT AGREEMENT

Dear New Patient,

Welcome to Dr. Wiles Goss Natural Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.

Please **read and initial** the following statements:

_____ Payment for all services, tests, and medicinary items is due at the time of service. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a \$35.00 NSF fee.

_____ We use a variety of nutritional supplements, homeopathic remedies, and botanical medicines. Once these products leave our office, we cannot bear responsibility for their storage or their use. For the health and safety of our patients, we cannot accept returns on any medicinary products.

_____ We only accept certain insurance plans at this time. If your plan has out-of-network naturopathic coverage, we will happily provide all the appropriate coding and documentation to submit to the insurance provider.

_____ Your health care provider may prescribe medication, which may be purchased at the clinic or elsewhere. Your insurance company may not cover the medicinary items that are prescribed.

_____ To provide you with the most comprehensive care, we must set aside large blocks of time for your treatments. Please understand that you will be charged a missed appointment fee of \$50.00 for any missed appointments or late cancellations (less then 24 hours notice).

I have read and understand the above-stated policies of Dr. Wiles Goss Natural Health, LLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Date ____/____/____

Patient Signature (Parent/guardian signature if minor)