Jana Panter | ND, CST-T

Pediatric Health History Form: Under 13 years old

General Information: _____ Today's Date: _____

Child's Name: _____ DOB: _____

Parent or Guardian name(s): _____

Address: _____ City, Zip: _____

Phones: Primary: _____ Other: _____

Email: _____ Referred by: _____

Pediatrician's name and phone: _____

Doctor's name and phone: _____

Child lives with: _____

Allergies (topical and internal): _____

Current medications and supplements: _____

Nightly amount of sleep: _____ Activities and interests: _____

Average stress level and causes: _____

_____

Other alternative therapies child has experienced: _____

Please list primary reasons for seeking CST: _____

_____

_____

Child's Health History:

For each system listed below please describe current concerns first and past concerns next. Be sure to include any accidents, illnesses, or chronic problems. (In parentheses are examples).

Gestation/Birth (pre-eclampsia, induced labor): _____

_____

Skeletal/ bones (broken bones, scoliosis, back pain): _____

_____

Muscular, Connective Tissue/ muscles, joints (*sprains, torticollis*): _____

_____

Eyes, Ears, Nose, Throat, Mouth (braces, hearing problems, speech, sore throats, ear infections): _____

_____

Is s/he wearing? ☐ contact lenses ☐ hearing aids

Respiratory/ lungs (asthma, bronchitis, frequent colds, pneumonia): _____

_____

(please continue on other side)

Circulatory/ heart, arteries, veins, blood (hypertension, bleeds or bruises easily, murmurs): _____

_____

Nervous System/ brain, nerves (concussions, ADD and behavioral issues, seizures, ringing in ears, shooting pains, depression):

_____

_____

Digestive & Elimination/stomach, intestines, bladder (*constipation, irritable bowel, urinary tract infection*): _____

_____

Skin (rashes, psoriasis, eczema, warts): _____

_____

Endocrine/pituitary, hypothalamus, reproductive, thyroid (*growth problems, diabetes*): _____

_____

Menstrual History: _____

Anything else (significant family history, car accidents): _____

_____

More details on any information listed on this form: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Your signature below signifies acceptance of the following policies:

Health Information

I have filled out the Health History form completely and accurately to the best of my knowledge. I will keep Dr. Panter informed of changes to my health or healthcare.

Scope of Practice

I understand that Dr. Panter does not provide primary medical care. She recommends that I see my primary care doctor regularly and contact them for health care concerns. In case of emergency I will contact 911.

Client Confidentiality

Dr. Panter does not sell client information. I understand that she will not share any of my information with any persons or organizations unless 1) required by law to do so or 2) when necessary to consult with other health care professionals to provide optimal care or 3) you request the release of your medical records (see below).

Release of Medical Records

I authorize the release of all of my medical records for the purpose of claims processing, to the following: my attorney, the healthcare providers attending to this condition, and insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through my attorney.

Payment

Payment is expected at time of service. Cash, check, Venmo, or PayPal are accepted. Dr. Panter is happy to provide a Superbill. Please request it when scheduling.

Cancellation

A 48-hour notice is required for cancellation of an appointment. For less than 48-hour notice I will be charged for the full appointment.

Privacy Practices

I have read, understand and been offered a copy of Dr. Panter's Private Practices Policy Form (the HIPPA).

_____ _____

Parent or guardian Date

Dr. Panter
jana.panter@outlook.com