Welcome to Shaw Family Practice,

We are so happy to have you here. Thank you for trusting us with your health.

On your first visit you will sit down with Dr. Shaw and discuss your goals, where you are now, how your life has shaped your current level of health. Dr. Shaw uses both naturopathic and chiropractic care to meet your needs. These healing techniques are based in preventive medicine and looking at the entire picture as a complete human being with physical, mental, and emotional health we address all of them here.

After you have shared what brought you in, Dr. Shaw will take you through a physical exam. She will talk with you so that you know what each test means, what she is looking for, and answer any questions you have along the way. With those results she will work with you to set goals, a timeline, and discuss a course of treatment to meet your goals.

This practice is a safe place for families. No need for babysitters, feel free to bring children, spouses, and friends. We invite you to bring your whole family to your visits at our office.

Should you feel the need to reach out, please do so. Dr. Shaw will reply as soon as she can.

We are glad you are here,

Shaw Family Practice

970-658-1281
148 W Oak St, Suite C. Fort Collins, CO 80524
ShawFamilyPractice.com

DR. SHAW DC, ND

HARNESS THE POWER OF NATURE

SHAW FAMILY PRACTICE

Pediatric Health History: Thank you for coming in, we are glad you are here. Please sit down and take your time with this detailed paperwork. The more information we review in your case the better care we can provide.

Child's Name _____ Birthdate _____Gender _____
Nickname: _____ School/daycare:_____
Pediatrician: _____
Sibling's Names and Ages: _____
Guardian's Name: _____Relationship: _____
Address _____City _____ State_____ Zip_____
Phone: (_____)_____ Email_____@_____.com
Would you like to receive online support through email or video with our office? Yes No

EMERGENCY CONTACT	
Name:	Address:
Phone:	
Relationship to patient:	

How did you hear about us? Many of our patients are referred by their friends, family, co-workers and doctors. These individuals are concerned for your health and have shown their trust and confidence in Dr. Shaw to provide you with the very best care possible. Please let us know how you heard about us so we can send them a "Thank You".
Google Facebook Event Midwife_____ Referral:_____

Authorizing Consent for examination: Please Read Carefully
In order for Dr. Shaw to make a determination on the suitability of my case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. Shaw, or any party authorized to do so by that person. I understand that there may be risks with examinations and adjustments, as there are with any and all healthcare treatments. I understand that I may ask the doctor to stop the examination or treatment at any time. I understand by signing this form, the doctor continues to be obligated for best practices delivered in my interests.
Signature: _____ Date: _____

COLORADO SURPRISE/BALANCE BILLING DISCLOSURE
Surprise Billing – Know Your Rights: Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." **Provider: Dr. Shaw is out-of-network, you are responsible for the costs of services provided.** If you receive services from an out-of-network provider, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed. If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.
ACKNOWLEDGEMENT OF RECEIPT OF COLORADO SURPRISE/BALANCE BILLING DISCLOSURE This document is to be signed by the patient or a person legally responsible for the patient's medical decisions relative to the treatment situation.I acknowledge that Shaw Family Practice has provided me with a copy of the Colorado Surprise/Balance Billing

Disclosure. My signature below indicates that I understand that Shaw Family Practice is an out-of-network facility which does not participate with any insurance providers. I further understand that all of the services I receive at Shaw Family Practice will be performed by out-of-network providers.

Signature: _____ Date: _____

Naturopathic Care Disclosure

Dr. Shaw DC,ND was trained in naturopathic medicine at National University of Health Sciences. This practitioner received her degree after four years of graduate-level clinical and academic training, as well as the completion of rigorous basic science and clinical science board exams. This naturopathic doctor is registered, but not licensed, in the State of Colorado. The Division of Regulatory Agencies (DORA) is the regulatory board for naturopathic doctors in Colorado. Any complaints regarding our professional services should be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, please contact the Division at (303) 894-7414 or www.dora.state.co.us.

As a Naturopathic Doctor, registered by the state to practice naturopathic medicine, under the "Naturopathic Doctor Act," I am not permitted to perform the following acts: • Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs). • Perform surgical procedures, including surgical procedures using a laser device. • Use general or spinal anesthetics, other than topical anesthetics. • Administer ionizing radioactive substances for therapeutic purposes. • Treat a child who is less than two years old without the family also seeing a pediatrician. • Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one. • Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine. Practice obstetrics. Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner. Dr. Shaw is an active member of the Colorado Association of Naturopathic Doctors (www.coand.org). No license or registration has ever been revoked or suspended. The privacy of your medical information is important. This office complies with the United States HIPPA Patient Privacy Guidelines. Detailed information regarding these guidelines is available upon request. As a patient of Shaw Family Practice, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. You may seek a second opinion from another health care professional or may terminate therapy at any time. Dr. Shaw is not a medical doctor or physician licensed under Title 12, Article 36, of the Colorado Revised Statutes. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric health care provider. If the patient is a child aged two to seven, we are required to recommend that the child's parent or guardian follow the immunization schedule that accompanies this form. If the patient has a relationship with a licensed physician or pediatric health care provider, we will attempt to develop and maintain a collaborative relationship with the physician or pediatric health care provider.

Signature: _____ Date: _____

Informed Consent for Chiropractic Spinal Manipulation, Authorization and Release

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition. **Possible risks:** Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold,

and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury. **Other options** for the treatment of pain include: do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Chiropractor, Dr. Jo Nell Shaw DC, ND.Signature: _____Date _____

FINANCIAL AGREEMENT

Shaw Family Practice is not a participating provider with any insurance companies. Our office does not file or submit claims to any health insurance plan. At your request, we can provide you with a receipt of services (SuperBill) that you can send to your insurance company for your reimbursement under your out-of-network plan. **Medicare:** Dr. Shaw is not a participating provider for Medicare. If you choose to use your Medicare plan we will happy to refer you to a participating provider. Workers Compensation: Dr. Shaw does not participate in workers compensation claims at this time. If you become injured on the job we would be happy to refer you for the appropriate care. **Payment:** Shaw Family Practice requires payment at the time of service. We currently accept debit and credit cards (Visa, MasterCard and Discover) cash, and checks. **Individual Consideration Contract:** If there is a financial hardship associated with receiving care in our office, payment arrangements can be negotiated with Dr. Shaw, and MUST be done prior to the time of service. Written agreements are required before treatment. **Past Due Accounts**: If your account becomes past due, we will take necessary steps to collect this debt. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of $35 our bank charges us for any returned checks. Balances beyond 30 days will be charged an additional 1.5% of your total balance per month plus any additional costs necessary to collect the balance owed. If we have to refer your account to a collection agency, you agree to pay all of the collection agency fees or commissions that are incurred. We reserve the right to refuse future services until your account is in current status. Signature: _____ Date _____

Cancellation and Missed Appointment Policy: We require a minimum of 24 hours notice when a patient cancels or reschedules their appointment. When a patient does not show up for an appointment and/or cancels / reschedules with less than 24 hours notice, a charge of 50% visit fee will be applied to the patient's account. If short notice cancellations or no-shows are frequent you will be asked for payment at the time of scheduling. I have read this agreement, understand it and agree with its provisions. I do clearly understand that I am ultimately responsible for the payment of fees for services rendered to me, or my family at this clinic. I authorize the doctors to administer such treatment as necessary. I do understand that no guarantees have been made as to the results of treatment. The ultimate financial responsibility remains with you, the patient. By signing this you are consenting to receive care. Signature: _____ Date _____

Thank you for signing all of the spaces above, they are what is required by law, I appreciate your patience. Take a big breath, Now let's focus on you and why you are coming in today!

WHY THIS FORM IS IMPORTANT: Our focus is on families to function optimally, to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your child's physical, emotional and chemical stresses that can gradually overwhelm the body and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

People seek care for a number of reasons and have certain expectations and perceptions.

___Improvement in function	___ Stress reduction	___ Improved breastfeeding
___ Pain reduction/relief	___ Learning issues	___ Early detection of problems
___ Improved quality of life	___ Optimum function	___ Headache relief
___ Manage my crisis	___ Improved performance	___ Ear infections
___ Reading/grades	___ Overall Wellness	___ Mental/emotional balance
___ Head shape	___ Disease prevention	___ Brain health
___ Immune support	___ Growth and Development	Other_____

What are you seeking help with? _____
What is your primary reason for seeking care at our office: _____
How long has this been a problem? _____
What do you believe the cause is? _____
What makes this worse?_____
What makes this better?_____
Is the problem worse during a certain time of the day? ▫ Yes ▫ No _____
Does this interfere with sleep? ▫ Yes ▫ No Eating? ▫ Yes ▫ No Daily routine? ▫ Yes ▫ No
Is this becoming worse? ▫ Yes ▫ No

What goal, if you were to complete or accomplish it, would have the greatest impact on your child's life?

_____

_____

Has your child ever received chiropractic care? Yes /No Have they ever seen a Naturopathic doctor? Yes/No
If yes, who is your previous Chiropractor or Naturopathic doctor?_____
May we contact them? ▫ Yes ▫ No In the last year have you had these tests done? ▫ Bloodwork ▫ Urine ▫ X-Rays
Circle your level of commitment to your child's health? (Bare minimum)-1 2 3 4 5 6 7 8 9 10- (Total)
List below any other health information you feel is important:_____

_____

Review of Systems: Please check items your child has or have had in the past **3 months.**

Constitutional
__chills
__fatigue
__fever
__ night sweats
__weight gain/loss

Eyes
__blurred vision
__glasses/contacts
__sensitivity to light

Ears/Nose/Throat
__ear pain
__hearing problems
__ringing in ears
__nose bleeds
__dental disease
__tooth pain
__hoarseness
__thrush

Cardiovascular
__chest pain
__pain/leg cramp
__palpitations
__leg swelling
__fast heart beat
__varicose veins

Musculoskeletal
__joint pain
__joint stiffness
__pain in arms/legs
__muscle spasm/ache

Respiratory
__cough/wheezing
__difficulty breathing
__exposure to TB
__coughing up blood

Gastrointestinal
__abdominal pain
__acid reflux
__bloating
__difficulty swallowing
__heartburn
__nausea/vomiting
__vomiting blood
__constipation
__diarrhea
__red blood in stool
__hemorrhoids
__dark tar-like stools

Genitourinary
__painful urination
__blood in urine
__frequent UTI
__waking to urinate
__frequent urination
__urinary incontinence
__ discharge
__genital itching/lesions
__sexually transmitted infections
__history of vaginosis
__irregular menstrual cycle
__excessive menstrual flow
__painful periods

Skin and Breast
__acne/mole(s)
__eczema/rashes
__breast mass
__nipple discharge

Hematologic/Lymphatic
__easy bruising
___excessive bleeding
___swollen lymph nodes
___hemophilia

Neurological
__fainting/dizziness
__headaches
__memory loss
__numbness/tingling
__seizure/tremor
__vertigo
__weakness

Endocrine
__hair loss/hair growth
__heat/cold intolerance
__excessive thirst/hunger
__excessive sweating

Allergic/Immunologic
__seasonal allergies
__food allergies/sensitivities
__frequent infections
__autoimmune disease

Psychiatric
__anxiety/feeling stressed
__depression/mood swings
__personality changes
__PMS (premenstrual syndrome)

Anything else come to mind?

_____
_____
_____
_____
_____
_____
_____
_____

Family Health History

Is there anyone in your family with any of the following medical conditions?

Condition	Who and type of illness	Condition	Who and type of illness
Cancer		Diabetes	
Arthritis		Stroke	
Autoimmune		Autism	
High blood pressure		Heart disease	
Lung disease/ asthma		Mental illness	
High cholesterol		Other	

Reproductive aged Females

When was your first period? _____ List the first day of your last period: _____

Are your cycles regular? _____ How many days of flow? _____

Any history of sexually transmitted infections or diseases?_____

Reproductive aged Males

Have you had any alteration in urinary frequency, flow of urine stream? _____

Any history of sexually transmitted infections or diseases?_____

Physical Stressors: Dr. Shaw looks for and detects problems related to many activities of daily life, please share any information you have on the following: Birth weight _____lbs _____oz Were there any complications? No/Yes

Was child born: ▫ cephalic (head first) ▫ breech (feet first) Position:_____

Where was the birth? ▫ home ▫ birth center ▫ hospital ▫ other _____

Was labour: ▫ spontaneous ▫ induced Medications or epidurals? ▫ Yes ▫ No _____

Assistances used during delivery: ▫ Forceps ▫ Vacuum extraction ▫ Episiotomy ▫ C-section

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) ▫ Yes ▫ No

If yes, please explain _____

Any evidence of birth trauma to the infant?

- ○ bruising
- ○ odd shaped head
- ○ fast birth
- ○ excessively long birth
- ○ respiratory depression
- ○ cord around neck

Any falls from couches, beds, change tables, etc? ▫ Yes ▫ No_____

Any traumas resulting in bruises, cuts, stitches or fractures? ▫ Yes ▫ No_____

Any hospitalizations or surgeries? ▫ Yes ▫ No If yes, please explain _____

Any sports played_____

Is a school backpack used? ▫ Yes ▫ No Is it ▫ heavy or ▫ light? _____

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? ▫ Yes ▫ No

What concerns do you have: _____

At what age did the child:

Respond to sound _____ Sit alone _____ Teethe _____

Hold up head _____ Crawl _____ Walk _____

Follow an object _____ Vocalize _____ Potty train _____

Does your child sleep: ▫ front ▫ back ▫side Naps (length of time and pattern): _____

How many hours of sleep a night_____

Do you consider the child's sleeping pattern normal? ▫ Yes ▫ No_____

Chemical Stressors: Our bodies have chemical stressors from exposure to toxins through our environment, food, air, water, and products we use on our skin, clothes and hair. Please share any information you can.

Was this child breastfed? ▫ Yes ▫ No If yes, how long: _____

Formula introduced at what age: _____ Which formula?_____

Introduction of cow's milk at what age: _____ Solid foods at what age _____

Food/Juice intolerance? ▫ Yes ▫ No Type: _____

Nutritional Information

Circle the meals your child eats typically: Breakfast Lunch Dinner #Snacks _____

On a scale of 1-10 (10 being extremely healthful). How do you rate your child's diet? _____/10

If you try to follow a specific diet, please describe it and why you follow this type of diet? _____

_____

Indicate any specific nutritional goals_____

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

▫ Never ▫ On weekends ▫ A few times per week ▫ Daily ▫ On special occasions

Are you aware of the impact of nutrition on children's behavior? ▫ Yes ▫ No

Would you like information on nutrition for your child? ▫ Yes ▫ No _____

Any pets at home? ▫ Yes ▫ No _____ Any smokers in the home? ▫ Yes ▫ No

Any antibiotics given? ▫ Yes ▫ No If yes, reason: _____

During the mother's pregnancy:

Did the mother smoke? ▫ Yes ▫ No What and How much? _____

Drink alcohol? ▫ Yes ▫ No What and How much? _____

Any illnesses during the pregnancy? ▫ Yes ▫ No If yes, describe:_____

Any supplements taken during pregnancy? ▫ Yes ▫ No If yes, describe:_____

Any drugs/medications taken during pregnancy? ▫ Yes ▫ No _____

Allergies: _____

Medication/Supplement	Reason	Prescribing doctor

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Other_____
Unusual Childhood Diseases:_____

Psychosocial Stressors

Any difficulties with lactation? ▫ Yes ▫ No Any problems with bonding? ▫ Yes ▫ No
Any behavioral problems? ▫ Yes ▫ No Any inattention? ▫ Yes ▫ No
Any hyperactivity or restlessness? ▫ Yes ▫ No Any difficulties at daycare/school? ▫ Yes ▫ No
Any challenges with learning deficiencies? ▫ Yes ▫ No _____
Any night terrors, sleep walking, difficulty sleeping? ▫ Yes ▫ No _____
Any prolonged temper tantrums or separation anxiety? ▫ Yes ▫ No _____

Number hours of television per week? _____ Number of hours of video games per week? _____
Does your child have a cell phone? ▫ Yes ▫ No How often are they on the phone? _____
Do you feel that your child's social and emotional development is normal for their age? ▫ Yes ▫ No

Please give any other insight/information that you feel might be helpful in your child's health maintenance:
_____
_____
_____
_____

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, ask Dr. Shaw.