



DR. PEGGY BRANSON, N.D.
1831 Orange Ave, Suite A
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PEDIATRIC PACKET

Welcome to Newport Integrative Health!!

Dr. Branson's goal is to provide you with the highest level of personalized care. She is committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail or fax completed forms prior to your appointment. This will allow Dr. Branson to help solve your problems more efficiently and enhance the quality of your care. Alternatively you may bring the forms in with you to your first appointment.

Consultations

Your initial visit will be a 60-minute consultation with Dr. Branson. Nutritional therapy and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and Dr. Branson will help you select and find the highest quality products. Follow up visits to review lab report or treatment programs are 30-minute visits.

Payment Options

Cash, checks or credit cards (MasterCard, Visa & American Express) are accepted for services rendered. Payment is due on the day of service.

Insurance Information

Newport Integrative Naturopathic Health, Inc. and Dr. Peggy Branson, N.M.D., Inc. do not bill insurance or Medicare and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. Laboratory tests may or may not be covered; this will depend on the terms of your insurance plan.

We encourage your questions and participation in all aspects of your care. We are looking forward to meeting you and providing you with naturopathic health care.

I look forward to meeting you!!

Dr. Peggy Branson, N.D.



Patient Contact Information

Name of Patient _____ Date of First Visit _____

Name of Parent(s)/Guardian(s) _____

Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (cell) _____

(home) _____

(work) _____

*Please check box by phone number if
it is OK to leave a detailed message
about your health*

Email address _____

Is it OK to use email to correspond about your health? ___ Yes ___ No

Would you like to receive our email newsletter? ___ Yes ___ No.

Age _____ Date of Birth _____ Gender: Female _____ Male _____

Live with: Parents _____ Other _____

School _____ Grade _____ Hours per week _____

Insurance Carrier _____ PPO / HMO (circle one)

How did you hear about Dr. Branson? Friend _____ (name)

Doctor/health provider _____ (name)

Lecture _____ (please specify)

Flyer _____ (please specify)

Internet _____ (website)

Other _____ (please specify)

Next of Kin or other to reach in an emergency _____

Phone _____ Address _____



Welcome to the Patient Portal!!

This is your way of digitally communicating safely and securely with your doctor and our front desk staff.

Please fill in your username and password here (please print clearly):

username: _____

password: _____

In your favorite web browser, visit us at <https://npihealth.phiportal.com> and enter your username and password. Click on the Message tab to start email communication.

The Patient Portal Website is a convenient way to access your medical information and communicate with your doctor.

Features:

- Private and secure- fully HIPAA compliant messaging.
- View Demographics information and request corrections
- Coming soon: Access to lab results!

The patient portal is suitable for brief clarification questions that take the doctor 5 min or less to read and respond. Any question that takes longer than 5 min to respond to or significantly changes the course of treatment please schedule an appointment. The patient portal is not suitable nor intended for any sort of emergency communication. Your doctor will reply to your email within 1-2 business days. Her response may be delayed over weekends, holidays, or due to technical difficulties or high volume of messages.

Please be aware that your communication with your doctor will become part of your medical record.



Important Patient Information

BILLING/ISURANCE

- Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
- You will receive an invoice at the completion of your visit.
- Dr. Branson does not bill insurance or Medicare. You can request a “superbill” that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that phone visits may not be reimbursed by your insurance carrier.

APPOINTMENTS

- In fairness to our patients and practitioners there is a 24-hour cancellation policy
- There is a \$50.00 fee for missed appointments and appointments cancelled within 24 hours of the scheduled appointment time.
- As a courtesy to our patients, we will use our best efforts to confirm appointments prior to the appointed time. It is however, the patient’s responsibility to keep the scheduled appointment or reschedule.
- The initial consultation with Dr. Branson is \$300 and follow-up appointments to review lab results or treatment programs in person or by phone are \$150
- There is no charge for brief e-mails via the portal or phone calls, as determined by Dr. Branson at her sole discretion. For non-urgent matters that would be best attended to during an appointment, Dr. Branson will request you either a) schedule an appointment or b) hold your question until your next appointment (this generally applies to questions that change the course of care or take longer than 5 minutes to respond to either by phone or email).

LAB TESTS

- Primex Laboratory is available to provide phlebotomy services at Newport Integrative Health.
- After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered and testing recommendations will be reviewed.
- Fees for standard testing can either be billed to the patients PPO insurance or a discounted price can be paid if remitted at the time of the blood draw. Most specialty testing is either paid at time of the draw directly to the laboratory or there may be co-pay and the remaining balance smutted to your insurance. Insurance coverage will vary and depend on the terms of your plan. To verify insurance coverage for laboratory tests please contact your insurance company.
- Some specialized lab tests take up to 5 weeks to be finalized and sent to the office. Dr. Branson cannot guarantee turn-around time on laboratory testing.
- You will receive a copy of your lab test in the mail.
- Dr. Branson does not mark up or profit in any way from the sale of lab testing kits that she orders for her patients.

PATIENT INITIALS _____



Important Patient Information

SUPPLEMENTS

- Nutritional supplements are available for patient convenience at Newport Integrative Health
- Patients are under no obligation to purchase their supplements at the office, and many of the same and similar products are available at your local health food store and/or online
- Your doctor may receive a commission for products sold for their patients
- Newport Integrative Health will ship supplements to your home at standard shipping fees (most typically \$4.80).
- Return policy: we are able to return unopened supplements within 30 days of purchase. We are unable to return any opened supplements.

PATIENT AWARENESS AND RESPONSIBILITY

- Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health.
- Dr. Branson will inform you of the therapies most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Branson.
- You are responsible for seeking professional medical attention from Dr. Branson or another facility for a worsening of your condition.
- You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- You are aware that you may be referred to another physician for treatment when needed.

EVENING AND WEEKEND CALLS

- Dr. Branson does not maintain regular call on the evenings and weekends.
- If you have a non-urgent question please call during clinic hours or feel free to use the patient portal to contact Dr. Branson directly or call and leave a message at the office and she will respond to your question during the work week.
- If you have an **urgent** question for Dr. Branson, you may contact the on-call doctor on nights and weekends at 949-743-5770.

EMERGENCIES

- In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

PATIENT SIGNATURE _____ Date _____
(or Patient Representative)

Indicate relationship if signing for patient _____



Consent for Naturopathic Treatment

Newport Integrative Naturopathic Health, Inc.

Dr. Peggy Branson, N.M.D., Inc.

1831 Orange Ave, Ste A. Costa Mesa, CA 92627

Tel: (949) 574-4978 Fax: (949) 574-9854

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not (collectively, the “doctor”).

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act and may include, but are not limited to, nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended are considered safe when taken as instructed in the practice of naturopathic medicine. I understand and agree it is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses and I agree to use herbs and nutritional supplements only as prescribed for me by the doctor. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, **if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.**

I have read, or have had read to me, the above information and have had an opportunity to ask questions about this consent and to discuss its contents with my legal counsel, to the extent I have deemed necessary. By voluntarily signing below, I hereby consent to receive naturopathic medical care from the doctor. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME (printed) _____

PATIENT SIGNATURE: _____ Date: _____
(or Patient Representative)

Indicate relationship if signing on behalf of patient _____



Doctor-Patient Arbitration Agreement

This Doctor-Patient Arbitration Agreement is entered into by and between NEWPORT INTEGRATIVE NATUROPATHIC HEALTH, INC., a California naturopathic doctor corporation (“Corporation”), and the undersigned patient (“Patient”). For purposes of this agreement, “Corporation” shall mean and include Corporation and each of its shareholders, directors, officers, employees, agents, independent contractors, representatives, successors and assigns, including, without limitation, DR PEGGY Branson, N.M.D. INC, and “Patient” shall mean and include Patient and all parties whose claims may arise out of or relate to the treatment or services provided by Corporation for Patient, including Patient’s spouse, heirs, legal representatives, successors-in-interest, assigns and any children, whether born or unborn at the time of the occurrence giving rise to any claim against Corporation. If Patient is a pregnant mother, the term “Patient” shall mean both the mother and the mother’s expected child or children.

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to binding arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of binding arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. In addition to disputes with respect to medical malpractice, the parties further agree that all disputes, disagreements, controversies, claims and counterclaims arising out of, related to or in connection with Corporation’s provision of services for Patient, whether based on statute, tort, contract, common law or otherwise (collectively, “Claims”), shall be resolved by binding arbitration as set forth in this agreement. Notwithstanding the foregoing, the parties agree claims within the jurisdictional limit of the Small Claims Court may be resolved by the Small Claims Court of the applicable jurisdiction and need not be arbitrated.

Article 2: Procedures and Applicable Law: The arbitration shall be administered by the Judicial Arbitration and Mediation Services (“JAMS”) pursuant to its Comprehensive Arbitration Rules and Procedures (the “Rules”) in place at the time of the Claim, unless the parties agree otherwise in writing. To the extent the Rules conflict with any term of this paragraph, the terms of this paragraph shall control. To commence arbitration of a Claim under this agreement, either party may contact the local office of JAMS. The arbitration shall be conducted before a single neutral arbitrator who is a retired judicial officer selected in accordance with the Rules and shall take place in Orange County, California. The arbitrator, and not any federal, state or local court or agency, shall have exclusive authority to resolve any Disputes between the parties that are subject to this agreement, including, but not limited to, any claim that all or any part of this agreement is void or voidable. The arbitrator shall have the authority to entertain a motion to dismiss and/or a motion for summary judgment by any party and shall apply the standards governing such motions under California law. Any Claim to be arbitrated under this paragraph shall be governed by the substantive law (and the law of remedies, if applicable) of California. The arbitrator is without jurisdiction to apply any different substantive law or law of remedies.

Article 3: Authority: The arbitrator shall have jurisdiction over the Claim and the decision of the arbitrator shall be final and binding upon the parties, except as otherwise provided in this paragraph. Depositions may be taken and discovery may be conducted in the manner to give each party a reasonable opportunity to conduct discovery, as designated by the arbitrator with good cause shown by the parties. The arbitrator’s award shall include the arbitrator’s written reasoned opinion and the arbitrator shall not have the power to commit errors of law or legal reasoning. At the request of either party made within 10 days after issuance of the award, the award shall be subject to affirmation, reversal or modification, following review of the record and arguments of the parties by a second arbitrator selected in accordance



with the Rules who shall, as far as practicable, proceed in accordance with the law and procedures applicable to appellate review by the applicable state court of appeal of a civil judgment following a court trial. The cost of the arbitrator's fees, including the costs of the facility and the administration of the arbitration, shall be shared equally by the parties. Each party shall bear its own attorneys' fees and costs. However, if any party prevails on a statutory Claim which affords the prevailing party attorneys' fees and costs, then the arbitrator may award reasonable attorneys' fees and/or costs to the prevailing party, applying the same standards a court would apply under the law applicable to the Claim. Judgment upon the arbitration award may be entered in any court having jurisdiction, or application may be made by either party to such court for a judicial acceptance of the award and an order of enforcement, as applicable.

Article 4: Negotiation or Mediation: The parties may, by mutual written agreement only, stay the commencement of the arbitration procedure from time to time to allow for any form of negotiation or mediation of the Claim.

Article 5: Time Limits for Demanding Arbitration: A written demand for arbitration must be submitted within the statute of limitations period applicable in a civil court or administrative forum. If a party does not submit and serve a written demand for arbitration for a Claim within the applicable statute of limitations period, such failure shall constitute an absolute bar to the institution of any proceedings in any forum with respect to such Claim and will constitute a waiver of any rights regarding such Claim.

Article 6: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition.

Article 7: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment), Patient should initial below:

Effective as of the date of first medical services: _____ Patient Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature

Authorized Provider Representative

Date

Date

If this consent is signed by a personal representative on behalf of the patient complete the following:

Personal representative's name: _____

Relationship to patient: _____

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
- 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Newport Integrative Health 1831 Orange Ave, Suite A Costa Mesa, CA 92627 P: 949.574.4978 F: 949.574.9854 E: frontdesk@npihealth.com

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact above. Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I _____ have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare operations

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

_____ Patient Signature ____/____/____ Date



HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are made possible when Dr. Branson has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible.

Are you currently receiving healthcare? Y N

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS?

List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Do you have any known contagious diseases at this time? Y/ N If yes, what? _____

CURRENT MEDICATIONS:

Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____



ALLERGIES: Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

HEIGHT & WEIGHT:

Weight: _____ lbs. Height: _____

IMMUNIZATIONS:

| | | | |
|-----------------------|-----|-------------|-----|
| Polio | Y N | Pertussis | Y N |
| Tetanus shot | Y N | Diphtheria | Y N |
| Measles/Mumps/Rubella | Y N | Hepatitis B | Y N |
| HIB | Y N | Influenza | Y N |

Any adverse reactions to immunizations? Please specify.

HOSPITALIZATION AND SURGERIES:

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-RAYS AND SPECIAL STUDIES:

X-rays, CAT scans, or other studies your child has had:

MEDICAL HISTORY:

Please check those that are applicable.

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic fever | |

Other: _____

Any known exposure to heavy metals (mercury or lead paint) or toxins (pesticides or asbestos)? Y/N



FAMILY HISTORY:

| | FATHER | MOTHER | SISTERS | BROTHERS |
|----------------------------|--------|--------|---------|----------|
| Age (if living) | _____ | _____ | _____ | _____ |
| Health (G=good P=poor) | _____ | _____ | _____ | _____ |
| Age at death (if deceased) | _____ | _____ | _____ | _____ |

Check (√) those applicable

| | | | | |
|-----------------------|-------|-------|-------|-------|
| Cancer | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ |
| Epilepsy | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ |
| Asthma/Hayfever/Hives | _____ | _____ | _____ | _____ |
| Anemia | _____ | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ | _____ |
| Glaucoma | _____ | _____ | _____ | _____ |
| Tuberculosis | _____ | _____ | _____ | _____ |
| Cause of Death | _____ | _____ | _____ | _____ |

BIRTH HISTORY:

Born at how many weeks gestation? _____ weeks

Length of labor _____ Weight at birth _____

Complications, if any _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

- | | |
|---|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cigarette, alcohol or drug use | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemical exposure |
| <input type="checkbox"/> Amalgam removal or fish intake | |

Other health concerns _____

As a baby, did your child have any of the following?

- | | | | |
|---|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blue baby | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other _____ |

Feeding: Breast fed ____ How long? _____ months/years Formula: milk or soy

Age Began:

Sitting _____ months Crawling _____ months Walking _____ months

First tooth _____ months Solid foods _____ months First words _____ months

SYMPTOMS:

Y = YES N=NO P= PAST



| | | | | | |
|-------------------|-------|-----------------|-------|-----------------|-------|
| Dizzy spells | Y P N | Nose bleeds | Y P N | Cries easily | Y P N |
| Heart murmur | Y P N | Bad breath | Y P N | Nervous | Y P N |
| Hair loss | Y P N | Constipation | Y P N | Nightmares | Y P N |
| Night sweats | Y P N | Diarrhea | Y P N | Unusual fears | Y P N |
| Headaches | Y P N | Gas | Y P N | Bone/joint pain | Y P N |
| Hearing loss | Y P N | No appetite | Y P N | Flat feet | Y P N |
| Sore throats | Y P N | Stomach aches | Y P N | Acne | Y P N |
| Light Sensitivity | Y P N | Vomiting spells | Y P N | Chronic rash | Y P N |
| Motion/car sick | Y P N | Canker sores | Y P N | Eczema | Y P N |
| Sleep problems | Y P N | Anemia | Y P N | Hives | Y P N |
| Extreme fatigue | Y P N | Frequent colds | Y P N | Bloody urine | Y P N |
| Bleeding gums | Y P N | High fever | Y P N | Burning urine | Y P N |
| Easy Bleeding | Y P N | Cough | Y P N | Frequent urine | Y P N |
| Easy bruising | Y P N | Wheezing | Y P N | Other _____ | |

DIET:

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Number servings *per week*

Number servings *per day*

Fish _____
 Red meat _____
 Chicken _____

Vegetables _____
 Fruit _____
 Water _____ in ounces

- Does your child eat refined sugar? Y N
- Does your child eat fast food? Y N
- Does your child eat food with artificial colors or preservatives? Y N
- Does your child eat artificial sweeteners? Y N

Extra Curricular Activities

PLEASE WRITE ANY ADDITIONAL INFORMATION (USE BACK IF NECESSARY)

