Issaquah Holistic Health, PLLC *Health Care for a Higher Quality of Life*

Alexandria Easter, ND • 450 NW Gilman Blvd Suite 205, Issaquah WA 98027
P: (425) 391-5270 F: (425) 391-8091

**Confidential Pediatric Patient Intake Form:**

Date_____

Name _____ Date of Birth _____ Sex M/F _____

Parents/Guardians Names _____

Address _____

City/State/Zip _____

Phone (home) _____ (cell) _____

Emergency Contact _____ Ph _____ Relationship _____

Insurance _____ Name of Insured_____

Date of Birth of Insured _____ Copay Amount_____

How did you hear about us? _____

**Current health concerns:**

_____

_____

**Medication Allergies:** _____

**Life Threatening Allergies to Foods or Insects:** _____

**Current Medications and Dosage**

1. _____ 2. _____

3. _____ 4. _____

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**Current Supplements**

1. _____ 2. _____

3. _____ 4. _____

**Family History:**

| | Mother | Father | Sibling | Grandparent | Aunt/Uncle |
|---|---|---|---|---|---|
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crohn's Disease/ Ulcerative Colitis | ☐ | ☐ | ☐ | ☐ | ☐ |

**Personal History:**

Do your child currently have any diagnosed medical conditions? _____

_____

Major Illnesses/Accidents (please include dates)? _____

_____

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**Birth History:**

Gestational age _____ weeks Vaginal Birth or Caesarian? _____

Complications during pregnancy or during the birth? _____

**Current Exercise/Activity:** _____

Amount and Frequency _____

**Diet:**

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Is your child a picky eater or have food eversions/avoidance? _____

Are there any foods you know bother your child digestively or behavior wise? _____

Do your child experience constipation, diarrhea, bloating/gas, or reflux/indigestion? _____

Was your child breastfed? _____ Birth to how many months? _____

Was your child formula fed? _____ How many months? _____

What foods were introduced first? _____

Bowel Movements, Frequency _____

Is it difficult for your child to have a bowel movement? _____ Does it contain blood or mucus? _____

Does your child struggle with bed-wetting or late toilet training? _____

Does your child have frequent accidents either urinary or fecal? _____

Does your child get frequent ear infections? _____ Suffer from eczema? _____

Does your child suffer from hyperactivity or issues with focus/concentration? _____

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**Vaccine History:**

Hep B Birth _____ 2 months _____ 6-18 months _____

Rotovirus 2 months _____ 4 months _____ 6 months _____

DTap 2 months _____ 4 months _____ 6 months _____ 15-18 months _____ 4-6 yr _____

Hib 2 months _____ 4 months _____ 6 months _____ 12-15 months _____

PCV 2 months _____ 4 months _____ 6 months _____ 12-15 months _____

IPV 2 months _____ 4 months _____ 6-18 months _____

MMR 12-18 months _____ 4-6 years _____

Hep A 12-24 months _____

Varicella (Chicken Pox) 12-18 months _____ 4-6 years _____

**Review of Systems: (Current or Past)**

| | | | |
|---|---|---|---|
| ☐ Nausea | ☐ Vomiting | ☐ Diarrhea | ☐ Constipation |
| ☐ Abdominal Pain | ☐ Reflux | ☐ Asthma | ☐ Allergies |
| ☐ Eczema | ☐ Psoriasis | ☐ Rash | ☐ Hives |
| ☐ Fatigue | ☐ Headache | ☐ Joint Pain | ☐ Dizziness |
| ☐ Numbness | ☐ Tingling | ☐ Muscle Pain | ☐ Weakness |
| ☐ Hair loss | ☐ Brittle nails | ☐ Anemia | ☐ Thyroid Issue |
| ☐ Failure to Thrive | ☐ Diabetes | ☐ Heart Murmur | ☐ Epilepsy |
| ☐ Ear Infection | ☐ Thrush | ☐ Irregular Menses | ☐ Early Puberty |
| ☐ Change Taste/Smell | ☐ Change in Vision | ☐ Frequent Sore Throat | ☐ Frequent Colds |
| ☐ Persistent Cough | ☐ Irregular Heart Beat | ☐ Difficulty Swallowing | ☐ Kidney Disease |
| ☐ Depression | ☐ Anxiety/Panic Attacks | ☐ Attention Issues | ☐ Memory Loss |