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

Alexandria Easter, ND • 450 NW Gilman Blvd Suite 201, Issaquah WA 98027
P: (425) 395-7542 F: (425) 657-0934

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: _____

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Current Medications and Dosage

1. _____ 2. _____

3. _____ 4. _____

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	☐	☐	☐	☐	☐

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Personal History:

Do your child currently have any diagnosed medical conditions? _____

_____

Major Illnesses/Accidents (please include dates)? _____

_____

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? _____

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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? _____

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 _____

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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