Lake Meridian Healing Arts, PLLC *Health Care for a Higher Quality of Life*

Alexandria Easter, ND • 15215 SE 272nd ST. Suite 105, Kent WA 98042
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