VITALITY NW
NATURAL MEDICINE CLINIC

0 to 3-Year-Old Intake

CHILD'S NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____

SEX ASSIGNED AT BIRTH: _____

PARENT'S NAME: _____ PARENT'S NAME: _____

LAST PHYSICIAN SEEN: _____ FOR WHAT?: _____

WHAT BRINGS YOU AND YOUR CHILD IN TODAY? _____

□ PRIMARY MANAGEMENT (WE KEEP TRACK OF VACCINES, WELL CHILD VISITS)

□ ADJUNCTIVE CARE (WE ACT AS A SPECIALIST AND YOU HAVE ANOTHER PCP)

□ ONE TIME ADVICE □ UNSURE AT THIS TIME

DOES YOUR CHILD HAVE ANY ALLERGIES TO MEDICATIONS, FOODS, OR ENVIRONMENTAL EXPOSURES? PLEASE LIST AND EXPLAIN ALLERGIC REACTION.

ALLERGY	REACTION

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PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOUR CHILD IS TAKING. INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS, MINERALS, HERBS, HOMEOPATHICS, AND PROBIOTICS.

MEDICATION	DOSE	DIRECTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS:

DO YOU HAVE STABLE HOUSING? □ YES □ NO

DO YOU HAVE ENOUGH FOOD TO EAT? □ YES □ NO

DO YOU FEEL SAFE IN YOUR HOME? □ YES □ NO

WHEN WAS YOUR KID'S LAST DENTIST APPOINTMENT? _____

WHEN WAS YOUR KID'S LAST VISION SCREENING? _____

WHO DOES YOUR CHILD LIVE WITH? _____

WHO HAS LEGAL MEDICAL DECISION-MAKING CUSTODY? (PLEASE LIST ALL NAMES)

_____

WHO CARES FOR YOUR CHILD? ARE THEY IN DAYCARE OR PRESCHOOL?

_____

DOES ANYONE IN THE HOUSE SMOKE TOBACCO? □ YES □ NO

HAS YOUR CHILD BEEN VACCINATED: □ YES □ NO

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MEDICAL HISTORY: PLEASE CHECK ANY SYMPTOMS YOUR CHILD HAS NOW OR HAS EXPERIENCED IN THE PAST WEEK:

□ NO KNOWN MEDICAL ISSUES
□ HEADACHE
□ TROUBLE SWALLOWING
□ REFUSING TO EAT/LOW APPETITE
□ RUNNY NOSE/CONGESTION
□ EAR PAIN
□ COUGH
□ TROUBLE BREATHING
□ REFLUX
□ ABDOMINAL PAIN
□ BLOATING
□ CONSTIPATION
□ DIARRHEA
□ VOMITTING
□ MUSCLE PAIN
□ FEVER OR CHILLS
□ TROUBLE SLEEPING
□ ANXIETY
□ FUSSINESS
□ RASH
□ OTHER SYMPTOMS

MEDICAL HISTORY: PLEASE CHECK ANY PAST DIAGNOSES

□ NO KNOWN MEDICAL ISSUES
□ ANXIETY
□ ANEMIA
□ BRAIN INJURY
□ CANCER
□ CELIAC DISEASE
□ CONCUSSION
□ ECZEMA
□ GASTRIC REFLUX
□ GENETIC DISORDER
□ SEASONAL ALLERGIES.

SURGICAL HISTORY: PLEASE INDICATE YEAR WHEN APPLICABLE

□ NO PRIOR SURGERY
□ APPENDECTOMY
□ OTHER: _____
□ TONSILLECTOMY
□ HERNIA REDUCTION

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FAMILY MEDICAL HISTORY: WHAT HEALTH CONDITIONS HAVE BEEN DIAGNOSED IN PARENTS, GRANDPARENTS AND SIBLINGS?

Family Member	Current Age/Age on Passing	Heart Disease	Diabetes	Cancer	Mental Health Disorders	Genetic Diseases	Thyroid Issues	Auto-immune Disease	Other Conditions
Mother									
Father									
M. Grandmother									
M. Grandfather									
P. Grandmother									
P. Grandfather									
Sibling									
Sibling									
Other:									

HOW MUCH SLEEP DOES YOUR KID GET?

□ 0 - 4 HOURS

□ 4 - 6 HOURS

□ 7 – 9 HOURS

□ 10+ HOURS

HOW MANY NAPS DOES YOUR KID TAKE? _____

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AVERAGE/TYPICAL DAILY DIET: PLEASE FILL THIS OUT AS BEST YOU CAN.

BREAKFAST	
LUNCH	
DINNER	
SNACKS	
DESSERT	
BEVERAGES	
WATER	