VITALITY NW
NATURAL MEDICINE CLINIC

4 to 17-Year-Old Intake

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

DATE OF BIRTH: _____ AGE: _____

GENDER: _____ SEX ASSIGNED AT BIRTH: _____

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

LAST PHYSICIAN SEEN: _____ FOR WHAT?: _____

WHAT BRINGS YOU AND YOUR CHILD IN TODAY? _____

□ PRIMARY CARE (WE WILL KEEP TRACK OF PREVENTATIVE HEALTH SCREENING LIKE VACCINES)

□ ADJUNCTIVE CARE (SPECIALIST CARE BECAUSE YOU HAVE A DIFFERENT 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

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

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

HAS YOUR CHILD BEEN VACCINATED? □ YES □ NO

WHEN WAS YOUR KID'S LAST DENTIST APPOINTMENT? _____

WHEN WAS YOUR KIDS LAST VISION SCREENING? _____

WHO DOES YOUR KID LIVE WITH? _____

WHO HAS LEGAL MEDICAL DECISION-MAKING CUSTODY? _____

_____

WHAT SCHOOL/CARE DOES YOUR KID ATTEND? WHAT GRADE? _____

_____

WHAT TYPE OF EXERCISE DOES YOUR KID DO AND HOW OFTEN? _____

_____

WHAT EXTRACARICULAR ACTIVITIES DOES YOUR KID PARTICIPATE IN? _____

_____

DOES ANYONE IN THE HOUSE SMOKE TOBACCO? _____

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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
□ VISION CHANGE
□ HEARING CHANGE
□ DIZZINESS
□ TROUBLE SWALLOWING
□ SORE THROAT
□ RUNNY NOSE/CONGESTION
□ EAR PAIN
□ COUGH
□ CHEST PAIN
□ SHORTNESS OF BREATH
□ HEART RACING
□ HEART SKIPPING A BEAT
□ HEARTBURN/REFLUX
□ CHANGE IN APPETITE
□ ABDOMINAL PAIN
□ BLOATING
□ CONSTIPATION
□ DIARRHEA
□ NAUSEA
□ VOMITING
□ MUSCLE PAIN
□NUMBNESS/TINGLING
□ FEVER OR CHILLS
□ INSOMNIA
□ ANXIETY
□ DEPRESSION
□ OTHER SYMPTOMS

MEDICAL HISTORY: PLEASE CHECK ANY PAST DIAGNOSES YOUR CHILD HAS RECEIVED

□ NO KNOWN MEDICAL ISSUES
□ ADHD
□ ANXIETY
□ AUTOIMMUNE DISEASE
□ ANEMIA
□ ASTHMA
□ BRAIN INJURY
□ CANCER
□ CONCUSSION
□ DEPRESSION
□ ECZEMA
□ FAINTING
□ GASTRIC REFLUX/HEARTBURN
□ GENETIC DISORDER
□ HAY FEVER/SEASONAL ALLERGIES
□ PALPITATIONS
□ PTSD
□ SLEEP APNEA
□ SEIZURES
□ SENSORY ISSUES
□ SLEEP ISSUES
□ TRAUMA
□ URINARY ISSUES
□ OTHER ISSUES

SURGICAL HISTORY: PLEASE INDICATE YEAR WHEN APPLICABLE

□ NO PRIOR SURGERY
□ APPENDECTOMY
□ EAR TUBES
□ HEART REPAIR
□ HERNIA REPAIR
□ TONSILLECTOMY
□ OTHER: _____

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SEXUAL ORIENTATION (IF KNOWN): _____

HAS YOUR KID EXPERIENCED PHYSICAL, EMOTIONAL, OR SEXUAL VIOLENCE IN THE PAST OR CURRENTLY?

□ YES □ NO

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:									

PLEASE LIST OTHER CARE PROVIDERS ON YOUR HEALTH TEAM, LIKE MEDICAL DOCTORS, ACUPUNCTURISTS, CHIROPRACTORS, MASSAGE THERAPISTS, AND OTHER PROVIDERS:

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HOW MUCH WATER DOES YOUR KID DRINK EACH DAY? _____

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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24 HOUR DIET RECALL: WHAT DID YOUR KID HAVE FOR BREAKFAST, LUNCH, DINNER, SNACKS, AND DESSERTS?

BREAKFAST	
LUNCH	
DINNER	
SNACKS	
DESSERT	
BEVERAGES	
WATER	