Northwest
INTEGRATIVE MEDICINE

Northwest Integrative Medicine Pediatric Intake

Please indicate which provider you have an appointment with today:

_____ Stephanie Culver, ND _____ Maeghan Culver, ND _____ Teresa True, ND

Patient Name: _____

Age: _____ **DOB**: _____

Identifying Gender: Male / Female / Other **Preferred Pronoun**: He/She/They

Parent Names: _____

Telephone: (h) _____ (c) _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email: _____

Emergency Contact: _____ **Relationship**: _____

Telephone: (h) _____ (c) _____

How did you hear about NWIM? _____

Note: Integrative preventative healthcare is enhanced dramatically when the practitioner has a complete picture of the patient physically, mentally, emotionally, and spiritually. We ask for your cooperation and patience as you complete this health history questionnaire. You may find that some of the information is difficult to recall. We only ask that you do your best. The more information you provide, the better we will be able to serve your needs.

Thank you for your cooperation and thoroughness. We look forward to working with you.

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HEALTH CONCERNS: Please list your most important physical, emotional, or mental health concerns. Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____

HEALTH GOALS: Please list your health goals, ranking the most important first

1. _____
2. _____

How do you rate your overall health? Excellent Good Fair Poor

HEALTH HISTORY

- When did you last receive medical care? _____
- Where (Clinic)? _____
- By whom (Practitioner)? _____
- Pharmacy: _____

MEDICATIONS & ALLERGIES

PRESCRIBED & NATURAL MEDICINES Please list all prescribed drugs, vitamins, herbs, and others you are taking at present, with dosage.	ALLERGIES/INTOLERANCES Please list any food, medication, or environmental allergies and your reaction to them

Please list the following:

Surgeries/ Date	Hospitalizations/Date

IMMUNIZATION HISTORY: Please indicate if you have received any of the following vaccines

Is your child on an **Alternate Vaccine Schedule? Y / N**

Hep A	Y N	Tetanus (DtAP/TdAP)	Y N	Polio	Y N
Hep B	Y N	Flu (seasonal)	Y N	TB	Y N
HPV	Y N	MMR (Measles/Mumps/Rubella)	Y N	Rotovirus	Y N
Chicken pox	Y N	Pneumococcal	Y N	HiB	Y N
		Meningococcal	Y N		

HISTORY- PERSONAL: Please list significant illness or diseases you have been diagnosed with in the past (ie. chicken pox, asthma) & the approximate date you were diagnosed.

1. _____
2. _____
3. _____

HISTORY- FAMILY: Please list ages and mark any major health problems. If deceased please list what they died from (ie. cancer, old age), and at what age.

Were you Adopted? Y N

ADD/ADHD	Y N	Autoimmune Disease	Y N	Blood Clots	Y N
Asthma	Y N	Bleeding Disorder	Y N	Childhood Cancer	Y N
Blood Clots	Y N	Deafness	Y N	Age of Onset: _____	
Diabetes	Y N	Heart Problems	Y N	Type of Cancer: _____	
Hepatitis	Y N	High Cholesterol	Y N	Sickle cell Disease	Y N
		Strabismus/Lazy Eye	Y N	Sudden Death	Y N

Has any family member or relative died of heart problems or had unexplained or unexpected sudden death before the age of 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)? **Yes / No**

Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem? **Yes / No**

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? **Yes / No**

Dental Health:

How many times a day do you brush your teeth? _____
How many times a week do you floss your teeth? _____
Have you seen a dentist in the past year? Y N

SOCIAL HISTORY

Primary Residence: ____Biological or Adopted Parents ____Foster Parents ____Mother ____Father ____Others: _____

Secondary Residence: ____Mother ____Father ____Others: _____

Smoker(s) in the Family: Y N

Smoking Allowed in Home: Y N

Home Type: ____Apartment ____Condominium ____House ____Mobile Home ____Others: _____

How Many hours per day do you spend watching television? _____

How Many hours per day do you spend on the computer/internet/phone? _____

How Many hours per day do you spend playing sports/exercising? _____

School: _____ **Grade:** _____

Have you traveled outside the US? Y N

- Where & when? _____

Is a parent serving in the military or traveling abroad? Y N

Safety:

Do you have the following at home?

Carbon Monoxide Detector	Y N	Do you use a car seat?	Y N	N/A	
Smoke Detector	Y N	Is it rear facing?	Y N		
Firearms	Y N	Do you use a seat belt?	Y N		

Hydration: How many glasses of
Water/day _____
Juice/day _____
Soda/day _____

HISTORY- PERSONAL:
Please indicate if you **are experiencing** or **have experienced** the following:

Prematurity	Y	N	**Food Allergies**	**Y**	**N**	Seasonal Allergies	Y	N
Anemia	Y	N	Bleeding Disorder	Y	N	Head Injury	Y	N
Constipation	Y	N	**Breathing Problems**	**Y**	**N**	Concussion	Y	N
Reflux	Y	N	**Asthma**	**Y**	**N**	Broken/Dislocated Bone	Y	N
Diabetes	Y	N	Pre-Diabetes	Y	N	Eczema	Y	N
Headaches	Y	N	Ear Infection	Y	N	Hearing Problems	Y	N
Snoring	Y	N	Vision Problems	Y	N	Strabismus/Lazy Eye	Y	N
Blood Clots	Y	N	**Heart Problems**	**Y**	**N**	Kidney Infection/UTI's	Y	N
ADD/ADHD	Y	N	**Seizures**	**Y**	**N**	Depression/Anxiety	Y	N
Mental Illness	Y	N	Autism/Asperger's	Y	N	**Learning /Developmental Delay**	**Y**	**N**

When you exercise do you have problems with:

Passing out or feeling like you will pass out?	Y	N
Chest pain or discomfort?	Y	N
Heart skipping beats or racing?	Y	N
Feeling lightheaded or more short of breath than expected?	Y	N
Feeling more tired or short of breath than your friends?	Y	N

Patient Signature (Age 13+):_____

Parent/Guardian Signature:_____