

# Primavita Family Medicine, PLLC

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**Welcome to our clinic!** Please answer all questions as thoroughly as possible to assist Dr. Shinsato in providing you the best care possible. This form is confidential and the information will not be released to anyone outside this clinic without your written permission.

**Please mail or fax this form to us 2-3 days before your visit so Dr. Shinsato may review your health profile.** Otherwise, please bring the completed form with you to your visit. If you have any questions, please make a note and ask Dr. Shinsato for clarification during your visit.

**If you have a good experience with our clinic, please tell others!** If you did not have a good experience with us, please tell us, we appreciate your feedback to help us serve you better. Thank you for your assistance!

## CHILD HEALTH PROFILE

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Sex: M F

Nickname/Preferred Name: \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

How do you prefer to be contacted?  Home  Cell  Work  Email

Email correspondence is available for patient's for questions regarding their current treatment plan. Email is considered to be unsecure and is not recommended for the discussion of certain sensitive health related conditions. I agree to email correspondence for treatment plan clarifications and understand that it is considered unsecure. **Please Initial** \_\_\_\_\_

Is it okay to leave a message?  Home  Cell  Work

May we send you clinical information?  Y  N

Date of child's birth: \_\_\_\_\_ Age: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Current Health Care Provider(s):	Type	Phone	Fax
	Pediatrician		

Date of last physical: \_\_\_\_\_

<i>Primary Health Concerns: Please prioritize 1 or 2 health concerns that you would like to address during your first appointment.</i>	<i>Prior Diagnoses</i>	<i>Prior Labs/Imaging</i>	<i>Prior Treatments</i>

**Note:** If there is an extensive history associated with your health concern(s), please attach a separate piece of paper with a timeline of events, including symptoms, diagnoses, lab tests, treatments, what has helped and what has not helped.

Please list other symptoms or concerns that you have:

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How did these conditions develop? Can you identify any traumatic events that may have caused or aggravated your child's health problems? What happened in your child's life around this time?

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Have you ever consulted:  Naturopathic Physicians  Acupuncturists  Chiropractors  Nutritionists  Other \_\_\_\_\_

What level of change to your living habits are you willing to make to improve your child's health and address underlying causes of your signs and symptoms? (0% being no commitment, 100% complete commitment)

0%   10   20   30   40   50   60   70   80   90   100%

What goals do you have for your visit today?

What long-term expectations do you have for working with Primavita?

Are there any lifestyle factors (i.e. food, sleep, stress, family dynamics, etc.) that you believe may be contributing to your child's health issues?)



**What childhood illnesses has your child had?**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Rubella (German 3 day measles) | <input type="checkbox"/> Measles (2 week) | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Chickenpox    |
| <input type="checkbox"/> Whooping Cough                 | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Polio          | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Roseola                        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Thrush         | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Mononucleosis                  | <input type="checkbox"/> Strep Throat     | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Colic         |
| <input type="checkbox"/> Rashes/cradle cap              | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Headaches     |

**Immunizations** (Please check all the immunizations your child has received):

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Polio              | <input type="checkbox"/> Tetanus          | <input type="checkbox"/> MMR (Measles/Mumps/Rubella) | <input type="checkbox"/> Pertussis (isolated)               |
| <input type="checkbox"/> Smallpox           | <input type="checkbox"/> Polio            | <input type="checkbox"/> Diphtheria (isolated)       | <input type="checkbox"/> DPT (diphtheria/pertussis/tetanus) |
| <input type="checkbox"/> Rubella (isolated) | <input type="checkbox"/> Mumps (isolated) | <input type="checkbox"/> Hepatitis B                 | <input type="checkbox"/> Chicken pox (varicella)            |
| <input type="checkbox"/> H. influenzae      | <input type="checkbox"/> Flu shot         | <input type="checkbox"/> Other (for travel) _____    |   |

Did your child experience any adverse reactions to any of the above vaccines?  Yes  No If yes, please list vaccine(s) and type of reaction: \_\_\_\_\_

Major Illnesses/emotional or physical trauma/ accidents:

Type	Date	Treatment Received	Outcome

Outpatient Procedures / Hospitalizations, surgeries/ special diagnostic studies:

Type of surgery/study	Date	Reason for procedure	Outcome/Results

Please list the members of your household, including ages of any other children:

\_\_\_\_\_

Do you have any family pets? Please list: \_\_\_\_\_

\_\_\_\_\_

**PRENATAL HISTORY**

Mother's age at child's birth: \_\_\_\_\_

Mother's health during pregnancy: (check any health issues that were present)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Bleeding                             | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Stress and anxiety | <input type="checkbox"/> Illnesses: _____    |
| <input type="checkbox"/> Strep B                              | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Rh incompatibility | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Thyroid problems                     | <input type="checkbox"/> Physical trauma | <input type="checkbox"/> Medications: _____ |  |
| <input type="checkbox"/> Cigarette, alcohol, drug consumption |  | <input type="checkbox"/> Other: _____       |  |
| <input type="checkbox"/> Emotional trauma                     |  |   |  |

**BIRTH HISTORY**

Term: Full / Premature / Late      Height at birth: \_\_\_\_\_      Weight at birth: \_\_\_\_\_

Length of labor: \_\_\_\_\_      Complications? \_\_\_\_\_

Did your child have any of the following after birth? Please check

- |                                       |                                    |  |   |   |
|---------------------------------------|------------------------------------|--|---|---|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Blue baby | <input type="checkbox"/> Colic             | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> Fever     | <input type="checkbox"/> Difficult Feeding |   |   |
| <input type="checkbox"/> Other: _____ |                                    |  |   |   |

Age began: Sitting: \_\_\_\_\_      Crawling: \_\_\_\_\_      Talking: \_\_\_\_\_      Walking: \_\_\_\_\_

**LIFESTYLE**

How would you describe your child's disposition? \_\_\_\_\_

Anything else you would like me to know about your child? \_\_\_\_\_

**DIET**

How many meals does your child generally eat each day? One Two Three More than three

Does your child: eat out often diet frequently skip meals frequently

Does your child have any special diet or eating restrictions? Yes No if yes, please explain \_\_\_\_\_

List the primary foods you include in your child's diet? \_\_\_\_\_

List the foods you exclude from your child's diet \_\_\_\_\_

Mark which of these your child consumes regularly Coffee Caffeinated teas Artificial Sweetner

Soda Processed foods Preservatives Refined foods Margarine Fast Food

List any other foods your child eats which you suspect may be harmful to your child's health \_\_\_\_\_

List any foods your child craves, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.) \_\_\_\_\_

List any foods to which your child has a bad reaction: \_\_\_\_\_

Is your child thirsty often? Yes No At night? Yes No

How much water does your child drink daily? \_\_\_\_\_

What temperature does your child prefer to drink? Hot Cold Room Temp.

Is your child: Breastfed Formula-fed Both

What type of formula: Milk Soy Other

At what age was food introduced? \_\_\_\_\_

Please list approximate age that your child started consuming the following foods (if applicable):

Vegetables \_\_\_\_\_ Meat, Poultry, Fish \_\_\_\_\_ Soda \_\_\_\_\_

Beans/legumes \_\_\_\_\_ Fruits \_\_\_\_\_

Dairy: \_\_\_\_\_ Fruit Juice \_\_\_\_\_

Grains: (rice, oats, etc.) \_\_\_\_\_ Sweets \_\_\_\_\_

Any Food Aversions? \_\_\_\_\_

**SLEEP**

Does your child have trouble falling asleep? Yes No If yes, what keeps them up? \_\_\_\_\_

Does your child wake at night and can't fall back to sleep? Yes No \_\_\_\_\_

Does your child have a bedwetting problem? Yes No \_\_\_\_\_

Does your child wake feeling refreshed? Yes No \_\_\_\_\_

Does your child have recurring dreams? Yes No If yes, what is the theme? \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

(Please list ages and if deceased, what they passed from and at what age)

**Mother's Side**

**Father's Side**

Grandfather \_\_\_\_\_ Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_ Grandmother \_\_\_\_\_

Mother \_\_\_\_\_ Father \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

Has any BLOOD RELATIVE had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Mental Illness          | <input type="checkbox"/> Autoimmune Condition |
| <input type="checkbox"/> Asthma/Hay Fever/Hives | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Alzheimers           |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Seizure/Epilepsy        | <input type="checkbox"/> Alcoholism/Addiction |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Sickle Cell/Thalassemia | <input type="checkbox"/> Obesity              |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Thyroid (hyper/hypo)   | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Tuberculosis (TB)       | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> Other _____             | <input type="checkbox"/> Other _____          |

### GENERAL STATUS

Listed below are factors which may or may not influence your child's state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your child's health.

- | BETTER                   | WORSE                    |                          | BETTER                   | WORSE                    |                  |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Winter                   | <input type="checkbox"/> | <input type="checkbox"/> | Spring           |
| <input type="checkbox"/> | <input type="checkbox"/> | Summer                   | <input type="checkbox"/> | <input type="checkbox"/> | Autumn           |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold                     | <input type="checkbox"/> | <input type="checkbox"/> | Heat             |
| <input type="checkbox"/> | <input type="checkbox"/> | Dampness                 | <input type="checkbox"/> | <input type="checkbox"/> | Dryness          |
| <input type="checkbox"/> | <input type="checkbox"/> | Open air (being outside) | <input type="checkbox"/> | <input type="checkbox"/> | Windows closed   |
| <input type="checkbox"/> | <input type="checkbox"/> | Change of weather        | <input type="checkbox"/> | <input type="checkbox"/> | Traveling        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ocean seashore           | <input type="checkbox"/> | <input type="checkbox"/> | Mountains        |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical exertion        | <input type="checkbox"/> | <input type="checkbox"/> | Upon rising      |
| <input type="checkbox"/> | <input type="checkbox"/> | Morning                  | <input type="checkbox"/> | <input type="checkbox"/> | Evening          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold application         | <input type="checkbox"/> | <input type="checkbox"/> | Warm application |
| <input type="checkbox"/> | <input type="checkbox"/> | Bath                     |                          |                          |                  |

Other things that make your child significantly better or worse: \_\_\_\_\_

### REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition your child now has, N = Never had, P = a condition your child has had in the past

#### MENTAL/ EMOTIONAL

- |  |   |   |   |                         |   |   |   |
|--|---|---|---|-------------------------|---|---|---|
| Treated for emotional problems?                                  | Y | P | N | Depression?             | Y | P | N |
| Mood Swings?   | Y | P | N | Anxiety or nervousness? | Y | P | N |
| Considered/Attempted suicide?                                    | Y | P | N | Tension?                | Y | P | N |
| Poor concentration?  | Y | P | N | Memory problems?        | Y | P | N |
| Do you have concerns with abuse / violence in your child's life? |   |   |   |                         | Y | P | N |

#### SKIN

- |               |   |   |   |                      |   |   |   |
|---------------|---|---|---|----------------------|---|---|---|
| Rashes?       | Y | P | N | Eczema, Hives?       | Y | P | N |
| Acne, Boils?  | Y | P | N | Itching?             | Y | P | N |
| Color Change? | Y | P | N | Perpetual Hair Loss? | Y | P | N |
| Lumps?        | Y | P | N | Night Sweats?        | Y | P | N |

#### HEAD

- |            |   |   |   |                  |   |   |   |
|------------|---|---|---|------------------|---|---|---|
| Headaches? | Y | P | N | Head Injury?     | Y | P | N |
| Migraines? | Y | P | N | Jaw/TMJ problems | Y | P | N |

**EYES**

Spots in Eyes?	Y	P	N	Cataracts?	Y	P	N
Impaired vision?	Y	P	N	Glasses or contacts?	Y	P	N
Blurriness?	Y	P	N	Eye pain/strain?	Y	P	N
Color blindness?	Y	P	N	Tearing or dryness?	Y	P	N
Double Vision?	Y	P	N	Glaucoma?	Y	P	N

**EARS**

Impaired hearing?	Y	P	N	Ringing?	Y	P	N
Earaches?	Y	P	N	Dizziness?	Y	P	N

**NOSE AND SINUSES**

Frequent colds?	Y	P	N	Nose Bleeds?	Y	P	N
Stuffiness?	Y	P	N	Hayfever?	Y	P	N
Sinus problems?	Y	P	N	Loss of smell?	Y	P	N

**MOUTH AND THROAT**

Frequent sore throat?	Y	P	N	Copious saliva?	Y	P	N
Teeth grinding?	Y	P	N	Sore tongue/lips?	Y	P	N
Gum problems?	Y	P	N	Hoarseness?	Y	P	N
Dental cavities?	Y	P	N	Jaw clicks?	Y	P	N

**NECK**

Lumps?	Y	P	N	Swollen glands?	Y	P	N
Goiter?	Y	P	N	Pain or stiffness?	Y	P	N

**RESPIRATORY**

Cough?	Y	P	N	Sputum?	Y	P	N
Spitting up blood?	Y	P	N	Wheezing	Y	P	N
Asthma?	Y	P	N	Bronchitis?	Y	P	N
Pneumonia?	Y	P	N	Pleurisy?	Y	P	N
Emphysema?	Y	P	N	Difficulty breathing?	Y	P	N
Tuberculosis?	Y	P	N	Shortness of breath?	Y	P	N
Shortness of breath at night?	Y	P	N				
Shortness of breath lying down?	Y	P	N				

**CARDIOVASCULAR**

Heart disease?	Y	P	N	Angina?	Y	P	N
High/Low Blood Pressure?	Y	P	N	Murmurs?	Y	P	N
Blood clots?	Y	P	N	Fainting?	Y	P	N
Phlebitis?	Y	P	N	Palpitations/Fluttering?	Y	P	N
Rheumatic Fever?	Y	P	N	Chest pain?	Y	P	N
Swelling in ankles?	Y	P	N				

**GASTROINTESTINAL**

Trouble swallowing?	Y	P	N	Heartburn?	Y	P	N
Change in thirst?	Y	P	N	Change in appetite?	Y	P	N
Nausea?	Y	P	N	Vomiting?	Y	P	N
Vomiting blood?	Y	P	N	Bowel Movements: How often?			
Blood in stool?	Y	P	N	Is this a change?			
Pain or cramps?	Y	P	N	Constipation?	Y	P	N
Belching or passing gas?	Y	P	N	Diarrhea?	Y	P	N

Black stools?	Y	P	N	Gall Bladder disease?	Y	P	N
Jaundice (yellow skin)?	Y	P	N	Ulcer?	Y	P	N
Liver Disease?	Y	P	N	Hemorrhoids?	Y	P	N

**URINARY**

Pain on urination?	Y	P	N	Increased frequency?	Y	P	N
Frequency at night?	Y	P	N	Inability to hold urine?	Y	P	N
Frequent infections?	Y	P	N	Kidney stones?	Y	P	N

**ENDOCRINE**

Hypothyroid?	Y	P	N	Heat or cold intolerance?	Y	P	N
Hypoglycemia?	Y	P	N	Diabetes?	Y	P	N
Excessive thirst?	Y	P	N	Excessive hunger?	Y	P	N
Fatigue?	Y	P	N	Seasonal depression?	Y	P	N

**IMMUNE**

Vaccinations?	Y	P	N	Reactions to vaccinations?	Y	P	N
Chronic Fatigue Syndrome?	Y	P	N	Chronic infections?	Y	P	N
Chronically swollen glands?	Y	P	N	Slow wound healing?	Y	P	N

**NEUROLOGIC**

Seizures?	Y	P	N	Paralysis?	Y	P	N
Muscle weakness?	Y	P	N	Numbness or tingling?	Y	P	N
Loss of memory?	Y	P	N	Easily stressed?	Y	P	N
Vertigo or dizziness?	Y	P	N	Loss of balance?	Y	P	N

**MUSCULOSKELETAL**

Joint pain or stiffness?	Y	P	N	Arthritis?	Y	P	N
Broken bones?	Y	P	N	Weakness?	Y	P	N
Muscle spasms or cramps?	Y	P	N	Sciatica?	Y	P	N

**BLOOD/PERIPHERAL VASCULAR**

Easy bleeding or bruising?	Y	P	N	Anemia?	Y	P	N
Deep leg pain?	Y	P	N	Cold hands/feet?	Y	P	N
Varicose veins?	Y	P	N	Thrombophlebitis?	Y	P	N

How would you describe the emotional climate of your home? \_\_\_\_\_

How stressful is your child's daily lifestyle? How well do you think they handle these stresses?

Is there anything that you feel is important that has not been covered?

***Thank you for taking the time to fill out this form! It helps me to provide you with the best care possible. I look forward to working with you! -Dr. Shinsato***