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 unsecured 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 unsecured. ***Please Initial*** _____

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: _____

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

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:

_____
_____
_____

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?

_____
_____
_____

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?)

Do you have any ideas about what triggered or caused your child's symptoms?

MEDICAL HISTORY

How would you describe your child's general state of health? ❒Excellent ❒Good ❒Fair ❒Poor

MEDICATIONS:

Current Prescriptions, Over-the-Counter Medications, & Supplements: ***(include oral, topical, and suppositories):***

Name of Product (Include brand for supplements)	**Date Started** (approximate)	**Prescribed by** (Dr.'s name or Self)	**Reason for taking**	**Dosage** ex. *drugs*: 100 mg *supplements*: 2 capsules, 1 tsp	**Frequency** Ex. 3 x/day	**Has it helped?**

Do you take or use the following?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisol	Y N	Antibiotics	Y N	Aspirin	Y N
Tranquilizers	Y N	Sleeping aids	Y N		

Are you sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? ❒Y ❒N
If yes, please list:_____
_____
What happens when you have an "allergy attack"? _____
What prior types of allergy testing have you had? _____

Over the last 2 years, how many times have you been treated with antibiotics, for what condition?_____
_____
_____
_____

PAST MEDICAL HISTORY

Prenatal/birth/feeding history:
Describe your pregnancy with your child: ❒Natural ❒Forceps ❒Epidural ❒C-section ❒Trauma
_____
Breast fed?_____ how long?_____ Formula (kind):_____how long?_____
Is your child adopted? ❒ Yes ❒ No

What childhood illnesses has your child had?

❒Rubella (German 3 day measles)	❒Measles (2 week)	❒Mumps	❒Chickenpox
❒Whooping Cough	❒Rheumatic Fever	❒Polio	❒Scarlet Fever
❒Rosella	❒Asthma	❒Thrush	❒Epilepsy
❒Mononucleosis	❒Strep Throat	❒Ear infections	❒Colic
❒Rashes/cradle cap	❒Constipation	❒Jaundice	❒Headaches

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

❒ Polio	❒ Tetanus	❒ MMR (Measles/Mumps/Rubella)	❒ Pertussis (isolated)
❒ Smallpox	❒ Polio	❒ Diphtheria (isolated)	❒ DPT (diphtheria/pertussis/tetanus)
❒ Rubella (isolated)	❒ Mumps (isolated)	❒ Hepatitis B	❒ Chicken pox (Varicella)
❒ H. influenza	❒ Flu shot	❒ 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)*

❒ Bleeding	❒ Nausea	❒ Stress and anxiety	❒ Illnesses: _____
❒ Strep B	❒ Diabetes	❒ Rh incompatibility	❒ High Blood pressure
❒ Thyroid problems		❒ Physical trauma	❒ Medications:_____
❒ Cigarette, alcohol, drug consumption			❒ Other:_____
❒ 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*
❒ Rashes ❒ Blue baby ❒ Colic ❒ Birth injuries ❒ Cerebral palsy
❒ Seizures ❒ Fever ❒ Difficult Feeding
❒ 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 Sweetener
❒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 bed wetting problem? ❒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:

❒Anemia	❒Kidney Disease	❒Arthritis
❒Heart Disease	❒Mental Illness	❒Autoimmune Condition
❒Asthma/Hay Fever/Hives	❒High Blood Pressure	❒Alzheimer's
❒Bleeding Disorder	❒Seizure/Epilepsy	❒Alcoholism/Addiction
❒Cancer	❒Sickle Cell/Thalassemia	❒Obesity
❒Diabetes	❒High Cholesterol	❒Osteoporosis
❒Thyroid (hyper/hypo)	❒Liver Disease	❒Glaucoma
❒Eczema	❒Tuberculosis (TB)	❒Stroke
❒ Other_____	❒Other_____	❒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	
❒	❒	Winter	❒	❒	Spring
❒	❒	Summer	❒	❒	Autumn
❒	❒	Cold	❒	❒	Heat
❒	❒	Dampness	❒	❒	Dryness
❒	❒	Open air (being outside)	❒	❒	Windows closed
❒	❒	Change of weather	❒	❒	Traveling
❒	❒	Ocean seashore	❒	❒	Mountains
❒	❒	Physical exertion	❒	❒	Upon rising
❒	❒	Morning	❒	❒	Evening
❒	❒	Cold application	❒	❒	Warm application
❒	❒	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	Hay fever?	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