PRIMAVITA
FAMILY MEDICINE

2723 152nd Ave NE, Redmond, WA 98052
Ph: 425 273 0741 Fax: 844 218 1125
info@primavitamedicine.com

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 bring this completed form to your First Appointment. The contents of this form is the basis of the Appointment. *If you are unable to print it, please come 30-40 minutes before your scheduled time and we will have a copy ready for you. This form takes approximately 30-40 minutes to complete, depending on your case history, so please allocate sufficient time. 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

For anyone 0-11 years old

Today's Date: _____

Name: _____ Sex: M / F

Nickname / Preferred Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____

E-mail Address: _____

How do you prefer to be contacted? ❒ Home ❒ Cell ❒ E-mail

E-mail correspondence is available for patients for questions regarding their current treatment plan. E-mail is considered to be unsecured and is not recommended for the discussion of certain sensitive health-related conditions. I agree to e-mail correspondence for treatment plan clarifications and understand that it is considered unsecured. ***Please initial:_____***

May we leave messages on your phone relating to your visit/s? ❒ Yes ❒ *No

May we send you clinical information? ❒ Yes ❒ *No

** If you would like for communications to remain confidential i.e. to only speak to you directly – we cannot leave a message on your phone or with someone else on your behalf.*

Date of child's birth: _____ Age: _____ Blood Type: _____

Ethnicity: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us: _____

Current Health Care Provider's Name	Clinic Name	Type	Phone
		Pediatrician	

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 health problems? What happened in your 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 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 child's 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?) ❒ Yes ❒ No Please provide details: _____

_____

_____

Do you have any ideas about what triggered or caused your child's symptoms? ❒ Yes ❒ No Please provide details:

_____

_____

MEDICAL HISTORY

How would you describe your child's general state of health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor
Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with appropriate dates:

_____

_____

_____

_____

MEDICATIONS:

Does your child take or use the following?

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

List all the drugs (prescription and over the counter pharmaceuticals) including dosages.

Brand & Name of Product	**Concentration** (ml/mg per unit)	**Type** (liquid, cap, tab)	**Amount Per Day**	**Why are you taking this?**	**Start date**	**Who prescribed it** (self/doctor)

Please attach another sheet if you require more space – please indicate details per above.

Is your child sensitive/allergic to any drugs, foods, chemicals, animals, environmental substances? ❒ Y ❒ N
If yes, please list: _____

_____

_____

What happens when your child has an "allergy attack"? Please provide details: _____

_____

_____

What prior types of allergy testing has your child had? ❒ Skin prick ❒ IgG blood test ❒ IgE blood test ❒ Oral testing in office ❒ Other: _____

CURRENT SUPPLEMENTS:

List all vitamins, minerals, herbs, homeopathics, with dosages:

Brand & Name of Product	**Concentration** (ml/mg per unit)	**Type** (liquid, cap, tab)	**Amount Per Day**	**Why are you taking this?**	**Start date**	**Who prescribed it** (self/doctor)

Please attach another sheet if you require more space – please indicate details per above.

Over the last 2 years, how many times has your child been treated with antibiotics, for what condition? _____

_____

_____

_____

_____

PRENATAL/BIRTH 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 ❒ Emotional trauma ❒ Other: _____

Describe the pregnancy with your child: ❒ Natural ❒ Forceps ❒ Epidural ❒ C-section ❒ Trauma

Term: Full / Premature / Late Height at birth: _____ Weight at birth: _____

Length of labor: _____ Complications? ❒ Yes ❒ No Details: _____

Did your child have any of the following after birth? (*please check any that apply*):

❒ Rashes ❒ Blue baby ❒ Colic ❒ Birth Injuries ❒ Cerebral Palsy

❒ Seizures ❒ Fever ❒ Difficult Feeding ❒ Other: _____

PAST MEDICAL HISTORY

What illnesses has your child had?

❒ Rubella (German 3 day measles) ❒ Measles (2 week) ❒ Mumps ❒ Chickenpox

❒ Whooping Cough ❒ Rheumatic Fever ❒ Polio ❒ Scarlet Fever

❒ Roseola ❒ Asthma ❒ Thrush ❒ Epilepsy

❒ Mononucleosis ❒ Strep Throat ❒ Ear infections ❒ Colic

❒ Rashes/cradle cap ❒ Constipation ❒ Jaundice ❒ Headaches

Immunizations: ❒ N/A ❒ Polio ❒ Tetanus ❒ Measles/Mumps/Rubella ❒ Pertussis ❒ Diptheria ❒ Hepatitis B ❒ Chicken pox ❒ H. influenzae ❒ Flu shot ❒ HPV ❒Other (for travel): _____
Did your child experience any adverse reactions to any of the above vaccines? ❒ Yes ❒ No If yes, please life vaccine/s and type of reaction: _____

_____

_____

Major illnesses, emotional or physical trauma/accidents (not already listed):

Type	Date	Treatment Received	Outcome

If your child has been in a motor vehicle collision, please ask us for a different document to complete. Further details are vital.

Outpatient procedures, hospitalizations, surgeries, special diagnostic studies:

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

Please attached another sheet if you require more space – please include details per above.

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

_____

_____

Do you have any family pets? If so, please list: _____

_____

Recent physical exam: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent blood work/urine test: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent PAP/pelvic or prostate exam: Date: _____ Results: ❒ Normal ❒ Other: _____
Recent mammogram (females over 40): Date: _____ Results: ❒ Normal ❒ Other: _____
Recent DEXA (bone density scan): Date: _____ Results: ❒ Normal ❒ Other: _____
Recent ❒ X-ray ❒ Ultrasound ❒ MRI ❒ CT scan Date: _____ Results: ❒ Normal ❒ Other: _____

LIFESTYLE

How would you describe your child's disposition? _____

_____

Anything else you could like me to know about your child? _____

_____

DIET

How many meals does your child generally eat each day? ❒ One ❒ Two ❒ Three ❒ More than three
When is your child's first meal of the day? _____ am/pm
Does your child: ❒ Eat out often ❒ Diet frequently ❒ Skip meals frequently ❒ Skip breakfast
Does your child have any special diet or eating restrictions? ❒ Yes ❒ No If so, ❒ dairy free ❒ gluten free ❒ paleo ❒ keto diet ❒ Other: _____

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 consume regularly: ❒ Coffee ❒ Caffeinated teas ❒ Artificial sweeteners ❒ Soda ❒ Processed foods ❒ Preservatives ❒ Refined foods ❒ Margarine ❒ Fast Food
List any other foods you eat 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, fatty foods, etc.*): _____

_____

List any foods to which you have a bad reaction (*please list the food and what the reaction is*): _____

_____

_____

Is your child thirsty often? ❒ Yes ❒ No At night? ❒ Yes ❒ No
How much water does your child drink daily? _____
What temperature do your child prefer to drink? ❒ Hot ❒ Cold ❒ Room temperature
Was your child breast fed? ❒ Yes, how long? _____ ❒ No Formula (kind): _____ How long? _____
When were solids introduced? _____ months old
Please list the approximate age that your child started consuming the following foods, if applicable:

Vegetables _____ Meat, Poultry, Fish _____ Soda _____

Beans/Legumes _____ Fruits _____ Fruit Juice _____

Dairy _____ Grains (rice, oats, etc.) _____ Sweets _____

Any food aversions? If so, please list:_____

Are you satisfied with your diet as it is now? ❒ Yes ❒ No If no, why not? _____

_____

SLEEP

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

_____

_____

Do your child wake at night and can't fall back to sleep? ❒ Yes ❒ No If yes, what keeps them up? _____

_____

_____

Does your child have a bed wetting problem? ❒ Yes ❒ No

Do 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	❒ Alzheimers
❒ 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 state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

BETTER	WORSE		BETTER	WORSE	
❒	❒	Winter	❒	❒	Spring
❒	❒	Summer	❒	❒	Autumn
❒	❒	Cold	❒	❒	Heat
❒	❒	Dampness	❒	❒	Dryness
❒	❒	Open air (being outside)	❒	❒	Windows closed
❒	❒	Change of weather	❒	❒	Traveling

BETTER	WORSE		BETTER	WORSE	
❒	❒	Ocean seashore	❒	❒	Mountains
❒	❒	Physical exertion	❒	❒	Upon rising
❒	❒	Morning	❒	❒	Evening
❒	❒	Cold application	❒	❒	Warm application
❒	❒	Bath	❒	❒	Before menstruation
❒	❒	During menstruation	❒	❒	After menstruation

Other things that make your child significantly better or worse: _____

_____

_____

_____

REVIEW OF SYSTEMS

FOR THE FOLLOWING, PLEASE CIRCLE

Y = a condition you now have; P = a condition you have had in the past; N = never had

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
Itchy ears (inside ears/eat canal)	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	Blood clots?	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? _____ per day/week			
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 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 us to provide you with the best care possible. We look forward to working with you! -Dr. Lorina Shinsato & Alexander Kim