Stellina Natural Medicine
12911 120th Ave NE, Suite E50
Kirkland, Washington, US - 98034

SNM Pediatric Intake Form 10 to 17 years

Pediatric Health History

Your Name

Relationship to Child

May we leave confidential voicemails at your primary phone number (lab results, treatment clarification, appointment questions, etc.)? *

☐ Yes ☐ No

How did you hear about our clinic?

For insurance billing, we need the Guarantor's name and relationship to the child. Example: John Doe, father *

Guarantor's date of birth: *

Reason for visit? *

Date of last physical exam

Does child have a primary care physician/other health care providers? Please list

Vital Information

Birthplace: City/State

Child's Gender Identity

Child's Pronouns

Parent Name *

Birth date *

Occupation

Height *

Weight

Co-Parent Name *

Birth date *

Occupation

Height *

Weight

Any living siblings * ☐ Yes ☐ No

Names and birthdates of siblings

Was child adopted? ☐ Yes ☐ No

If adopted, country of origin

Religious or Spiritual Preference

Birth Information

At birth, child received: *
☐ Vitamin K oral ☐ Vitamin K injection ☐ Newborn metabolic screening tests
☐ Hearing screen ☐ CCHD (congenital heart screen)

Family Background

Ethnic origin/heritage: (if known)

Birthing Parent *

Non-birthing Parent *

Parents are
☐ Married ☐ Living together ☐ Separated
☐ Divorced ☐ Single

Child lives with (please include custody arrangement if applicable) *
☐ Both parents in the same household ☐ Mother ☐ Father
☐ Guardian (specify)

Other members of household

Age of home or apartment

Any pets?

Has any parent, brother, or sister died? *

☐ Yes ☐ No

If yes, who?

Cause of death

Age

Please list important family history for the child's blood relatives listed below. If deceased, include cause of death and approximate age. Examples include cardiovascular, endocrine, genetic, neurologic and gastrointestinal conditions, cancers, allergies and anything significant regarding their health. If there is no relevant medical history or medical history is unknown, please state "none" or "unknown"

Birthing Parent *

Non-birthing Parent *

Maternal grandmother *

Maternal grandfather *

Paternal grandmother *

Paternal grandfather *

Siblings (example: brother - ADHD) *

Other relatives, please specify who and what health condition (example: maternal aunt - hypothyroidism) *

Nutrition

What has your child eaten over the past day?

Breakfast

Lunch

Dinner

Snacks ______

Fluids ______

Caffeine intake ______

Sleep and Elimination

Bowel movements per day ______

Urination per day ______

Typical Bedtime ______

Wake time ______

Sleep problems? ______

Medical history

Please check any illnesses or diseases that your child has had and give age

Measles, Mumps, or Rubella * ☐ Yes ☐ No

If yes, age ______

Chickenpox/ Varicella illness * ☐ Yes ☐ No

If yes, age ______

Whooping cough/pertussis illness * ☐ Yes ☐ No

If yes, age ______

Scarlet fever * ☐ Yes ☐ No

If yes, age ______

Rheumatic fever * ☐ Yes ☐ No

If yes, age ______

Convulsions/Seizures * ☐ Yes ☐ No

If yes, age ______

Strep throat * ☐ Yes ☐ No

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If yes, age ____________________

Anemia * ☐ Yes ☐ No

If yes, age ____________________

Heart Disease * ☐ Yes ☐ No

If yes, age ____________________

Allergies / Hay fever * ☐ Yes ☐ No

If yes, age ____________________

Eczema * ☐ Yes ☐ No

If yes, age ____________________

Asthma * ☐ Yes ☐ No

If yes, age ____________________

Pneumonia * ☐ Yes ☐ No

If yes, age ____________________

Hepatitis * ☐ Yes ☐ No

If yes, age ____________________

Ear Infection * ☐ Yes ☐ No

If yes, age ____________________

Other illnesses, if any ____________________

Has your child ever been injured? * ☐ Yes ☐ No

If yes, age? ____________________

Injury ____________________

Any fractures? ☐ Yes ☐ No

Which bone(s)? ____________________

Any loss of consciousness or concussion? ____________________

Any accidental poisoning? ☐ Yes ☐ No

If yes, at what age and what substance?

Has your child ever had surgery? * ☐ Yes ☐ No

If yes, at what age and type of operation?

Has your child ever been hospitalized other than for the above? * ☐ Yes ☐ No

If yes, describe

Has your child ever had a blood transfusion? ☐ Yes ☐ No

If yes, age

Has your child worn any of these? ☐ Glasses ☐ Contact lenses ☐ Leg braces ☐ Corrective shoes ☐ Orthotics in shoes

Please list all medications and supplements *

Does your child have allergies to any of the following?

Drugs * ☐ Yes ☐ No

If yes, specify

Foods * ☐ Yes ☐ No

If yes, specify

Environment * ☐ Yes ☐ No

If yes, specify

Please check if your child has had any of these *

- ☐ Frequent headaches
- ☐ Crossed eyes
- ☐ More than two earaches or ear infections a year
- ☐ Pinkeye
- ☐ Trouble hearing
- ☐ Frequent nosebleeds
- ☐ Stuffy nose most of time
- ☐ More than 6 colds a year
- ☐ Chronic cough
- ☐ Shortness of breath with exercise
- ☐ Heart murmur
- ☐ Constant or frequent fatigue
- ☐ Frequent stomachaches
- ☐ Frequent diarrhea or constipation
- ☐ Poor appetite
- ☐ Frequent urination or accidents
- ☐ Bloody, red, or brown urine
- ☐ Frequent bed-wetting after age 5
- ☐ Joint pains or swelling
- ☐ Dizziness or fainting spells
- ☐ Inability to get to sleep
- ☐ Frequent nightmares or sleepwalking
- ☐ Excessive thirst
- ☐ Excessive weight gain
- ☐ Signs of sexual development before age 9
- ☐ None of the above

School-related questions

Is child in school (or home schooled)? If so, what grade? *

School Problems *

- ☐ None
- ☐ Reading, writing
- ☐ Speech
- ☐ Behavior
- ☐ Special needs
- ☐ Social/peers

Are there any behavior problems at home? *

☐ Yes ☐ No

If yes, please describe

Risk Factor Screening

Is patient sexually active? *

☐ Yes ☐ No

Does patient use any of the following? *

- ☐ None
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Chewing tobacco
- ☐ Vape
- ☐ Marijuana
- ☐ Recreational drugs

Immunizations and Screenings

Immunizations up to date on standard CDC schedule *

☐ Yes ☐ No

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Selective immunizations and/or delayed schedule ☐ Yes ☐ No

Did they receive the COVID-19 vaccine? * ☐ Yes, 1 dose only so far ☐ Yes, both doses ☐ No

Please provide copy of immunization record.

Please give approximate dates for the following, if done :

Lead blood test ☐ Yes ☐ No

If yes, specify the Date and Result ______

TB skin test ☐ Yes ☐ No

If yes, specify the Date and Result ______

Vision exam ☐ Yes ☐ No

If yes, specify the Date and Result ______

Hearing test ☐ Yes ☐ No

If yes, specify the Date and Result ______

Hemoglobin blood test ☐ Yes ☐ No

If yes, specify the Date and Result ______

Urine test ☐ Yes ☐ No

If yes, specify the Date and Result ______

Others, please specify