Dr. Akiko Kato, ND
1900 116th Ave NE Suite 200
Bellevue, WA 98004
Phone: 425.954.6225
Fax: 425.214.1582
www.holisticfamilywellnessclinic.com

Pediatric/Adolescent Health History

Today's Date: _____

Patient's Name:_____ Age:_____ Date of Birth:_____ Sex:__

Mailing Address:_____

Name(s) of Parents/Guardians:_____

Phone (Home)_____ (Alternate #) _____

How did you hear about our clinic?_____

If you would like to receive our newsletters, e-mail address: _____

Does the patient have a pediatric or primary care MD? (if yes, name) _____

Person to be notified in case of an emergency:
Name:_____ Relationship to child:_____
Address:_____ Phone:_____

Please list your most important health concerns:

1.
2.
3.

List any prescription or over-the-counter medications:

List any allergies, including medication, food and environmental:

Childhood illnesses:

__Chicken Pox __Scarlet Fever __Mononucleosis

__Measles __Rheumatic Fever __Ear Infections
__Mumps __Strep Throat __Tonsillitis
__Rubella __Pneumonia __Croup
__Whooping cough __Asthma __Other:_____

Vaccinations:

Has your child been vaccinated?

Adverse reactions?

Hospitalizations, surgeries, accidents, serious injuries:

Family History: *(Check any that apply)*

__Alcoholism __Cancer __High Blood Pressure

__Allergies __Diabetes __Hypoglycemia

__Anemia __Eczema __Mental Illness

__Arthritis __Epilepsy __Obesity

__Asthma __Heart Disease __Stroke

__Birth Defects __Hearing Loss __Thyroid Disorder

__Other:_____

Patient's Health History: *(Check any that apply)*

NOW	PAST		NOW	PAST	
___	___	Acne	___	___	Epilepsy/Seizure
___	___	Allergies	___	___	Fatigue
___	___	Anemia	___	___	Frequent Headaches
___	___	Asthma	___	___	Headaches
___	___	Bed Wetting	___	___	Heart Murmur
___	___	Birth Defects	___	___	High Fever
___	___	Colic	___	___	Hyperactivity
___	___	Constipation	___	___	Insomnia
___	___	Cough/Wheeze	___	___	Jaundice
___	___	Cradle Cap	___	___	Learning Disorder
___	___	Depression	___	___	Moodiness
___	___	Diarrhea	___	___	Stuffy Nose
___	___	Dizzy Spells	___	___	Thrush

___ ___ Earaches ___ ___ Vomiting Spells
___ ___ Eczema

What is your infant's/child's disposition?

Prenatal/Birth/Feeding History:

Please answer questions regarding the mother's health during the pregnancy with this child.

Age _____ Trauma/injury? ____ Alcohol Consumption? ___
Bleeding? ___ Stress? _____ Drug use? ____
Nausea?_____ High blood pressure? ____ Smoking? ____
Illness? _____ X-Rays? _____ Other _____
Toxemia? ____ Medications? _____

TERM: Full ___ Premature ___ Late ____ Birth weight ___

Was Pregnancy/Birth..... Easy ___ Moderate ___ Difficult ___

Place of birth: Hospital ___ Home ___ Clinic ___ Other _____

FEEDING: Breast fed? ___ How long? ___
Formula fed? ___ What kind _____ How long? ___
Age solid foods introduced _____
Food intolerances? _____
Favorite foods? _____

Social History

Parents: Married ___ Separated ___ Divorced ___
Mother's occupation: _____
Father's occupation: _____

Daycare? _____

Siblings: *(Please list names, ages and health problems)*

Are there others living at home with the child?

Naturopathic Medical Consent: I consent to services rendered and provided to me under the instructions of the staff physicians of Holistic Family Wellness Clinic **Financial Agreement:** The undersigned, in consideration of services to be rendered to the patient, agrees to pay the provider of service, in accordance with their regular rates and terms, for the services rendered. All payment is due at time of service. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. All insurance benefits available for professional and clinic services rendered, will be returned to the patient to offset the costs incurred by the patient.

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Parent/guardian signature if patient is a minor: _____

Date: _____

Thank You!