

Vue Wellness Center
"Holistic Health for the Whole Family"
(425) 516-5500

Welcome to our clinic! Here's a checklist to help get you ready for your first visit:

- New patient paperwork filled out
- Bring all the supplements/medications that you are currently taking
- Women please wear pants (no skirts) to your visits
- Avoid wearing perfumes, essential oils, scented hair products, and scented lotions

The first visit will be approx one hour 30 minutes. Please arrive 10 minutes before your scheduled time. There is parking below the Skyline Tower that can be entered on 110th Ave, just South of 4th Ave. We are just one block from the Bellevue Transit Center and across the street from the Bellevue City Hall. The Bellevue Square Mall is only 5 blocks away.



Dr. Barry Wheeler, ND
Vue Wellness Center

Address:
Skyline Tower
10900 Northeast 4th Street
Suite 2300
Bellevue, WA 98004

Phone: (425) 516-5500
Hours: 8am - 5pm, Monday - Friday

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date: _____
Age: _____ Date of Birth: _____ Gender: Female / Male
Parent/Guardian's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone (home): _____ (Parent's work): _____
Parent's email address: _____
How did you hear about this clinic? _____
If internet: Google: _____ Other: _____
Has any other family member already been a patient at this clinic?: _____
Name of doctor's office/hospital/clinic where your child's health records are kept: _____
Reason for referral or presenting problems: _____

MEDICATIONS

NOW PAST

____ Aspirin
____ Tylenol
____ Antibiotics
____ Ibuprofen

NOW PAST

____ Decongestants
____ Anti-histamine
____ Other _____

Allergies to medicines: _____

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Patient: _____ Date of Birth: _____

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx no. of times: ____
____ Measles ____ Pneumonia ____ Ear infections, approx no. of times: ____
____ Mumps ____ Frequent colds ____ Strep throat, approx no. of times: ____
____ Rubella ____ Rheumatic fever ____ Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS
Electroencephalogram (EEG): _____
Psychological evaluations: _____
Hearing test: _____
Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list):

IMMUNIZATIONS

____ MMR ____ DPT ____ Chicken pox Others: _____
____ Measles ____ Diphtheria ____ Small pox Adverse reactions: Y / N
____ Mumps ____ Tetanus ____ H. influenza If so, what? _____
____ Rubella ____ Polio ____ The flu

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth: _____

Mother's health during pregnancy:

____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Medications ____ Diabetes ____ Thyroid problems

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late Weight at birth: _____

Length of labor: _____ Complications: _____

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Patient: _____ Date of Birth: _____

Did your child have any of the following problems shortly after birth?

____ Rashes ____ Birth injuries ____ Blue baby I palsy
____ Jaundice ____ Seizures ____ Cerebra
____ Colic ____ Fever ____ Birth defects
____ Other: _____

Child's sleep patterns (1st year):

Food intolerances: _____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy): _____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

____ Hives ____ Burning urine ____ Bloody urine ____ Eczema
____ Cries easily ____ Bleeding gums ____ Heart murmur ____ Nervous
____ Nose bleeds ____ Vomiting ____ Sleep problem ____ Asthma
____ Acne ____ Anemia ____ Night sweats ____ High fevers
____ Jaundice ____ Sensitive to light ____ Chronic rash ____ Stomach ache
____ Diarrhea ____ Hearing loss ____ Easy bruising ____ Sore throats
____ Flat feet ____ No appetite ____ Body/breath odor ____ Constipation
____ Nightmares ____ Frequent colds ____ Bleeding tendency ____ Unusual fears
____ Wheezing ____ Joint pains ____ Excessive fatigue ____ Cough
____ Dizzy spells ____ Hair loss ____ Frequent urination ____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.