Pediatric Intake Form

Patients name_______________________________________ date of initial visit________

Age: _________ date of birth _________ gender________

Parents names ____

Address:____

Phone_________________________________ __________________________________

Parents email address____

Pediatrician or GP____

Current Health concerns ____

Has the patient ever been treated with Acupuncture or TCM prior ___________________

Medical History

Chicken pox____ Scarlet fever_____ Roseola _______ Mononucleosis_________ Measles____

Pneumonia_____ Strep throat_____ Impetigo_______ Mumps_____ Whopping cough ______

Ear infections _____ Rubella_______ Rheumatic fever__________ other ________________

____

Please list any screening test you child has had ____________________________________

List all surgeries/ hospitalizations/ other serious or infectious illnesses________________

Allergies____

Medications/Supplements/ Vitamins/ Herbs

____

____

Birth History: Full term_____ Premature _____ Late______ Birth Weight________

Labor length/ complications____

Birth: Vaginal_______ C-section_______Induced_________ Anesthesia_______

Birth injury or abnormality: ___________ Breathing difficulty_______ Seizures_________

Jaundice_____ Fever________ Rashes_______ Weak cry _________

Feeding: Breast fed______ Formula_____ Type_______ Sleep patterns___________________

Age began: Sitting__________ Crawling___________ Walking__________ Talking__________

Dietary Sensitivities or Restrictions ____

____

SYMPTOMS: Please check your current symptoms, leave blank if not applicable

Head/Ears/ Eyes/ Throat

____Headaches ___Eye pain ____ Itchy/ watery eyes ___Nasal congestion

___ Migraines ____ Location ___Blindness ___ Sore throat

___ Dizzy/Vertigo ___ Numbness ___Frequent infections

___ Concussion/head trauma ___ Nose bleeds ___ TMJ ____Bad Breath

___Teeth grinding ____ Mouth sores ____ Sinus pain ______

Cardiovascular:

____ Irregular rate _____Irregular rhythm_____Hypertension ___ Hypotension

___ Fainting ____ Edema___ Frequent bruises____ Vivid dreams_____ Sleep difficulty_____

___Other ____

Respiratory_____ Shortness of breath _____ Asthma_____ Frequent colds ______ other

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GI/Gu

____ Pain ____ Bloating_____ Gas_____ Acid_____ Nausea/Vomiting_____ Indigestion

_____Bitter taste ____ Cravings. BMx per day____/Week____ _____Constipation

___ Diarrhea _____ Blood in stool ___ Mucus in stool ____ Rectal Pain _____ Rectal Itch

___ Painful urination _____ Frequent urination ____Frequent infection _____ Urine color_____

____ Other ____

Musculoskeletal

_____Acute pain ___ Chronic pain _____ Location of pain _________________________

___ Intensity of pain ______ Description of pain ___________________________________

____

___Muscle weakness _____ Muscle cramps____ Muscle spasms ____ Multiple joint pain ____

____Implants ____ Limited range of motion___ Numbness ___ Other

____

Skin/Hair/ Nails

__ Eczema ____ Rashes ____ Hives ____ Fungal infections ___ Redness ___ Vitiligo

___ Bald patches ___ Excess hair ___ Weak nails ___ Ridged nails ____ Discolorations

___ Piercings ____ Tattoos ____ Scars ______

___ Other ____

Mental/ Emotional/ Neurophysiological

____ Frightens easily ___ Angers easily ____ Cries easily ____ ADHD _____ Depression

___ Irritable ___ Suicidal ideation ___ Suicidal attempts ____ Stress ____ Anxiety ____Grief

____ Lethargy ____ Abuse survivor ____ Previous/ongoing counseling ___ Other

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Menstruation

___Age at Menarche ____ Cycle regular ___ Cycle irregular ___ Mid cycle pain _

__Other____

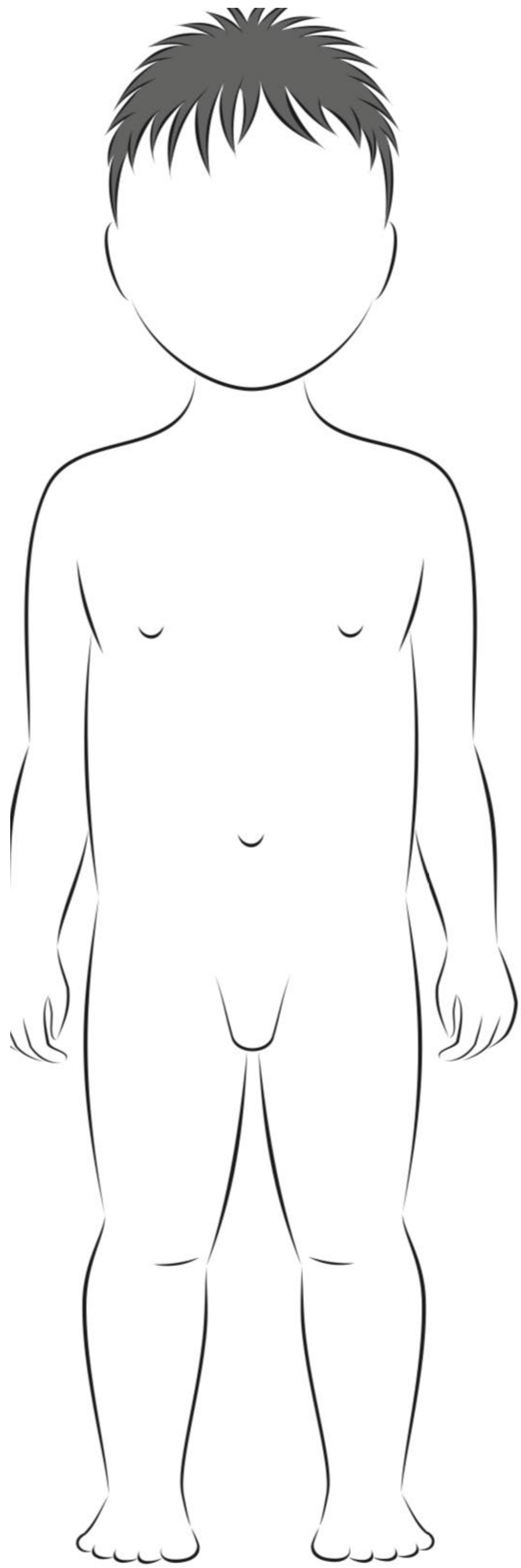
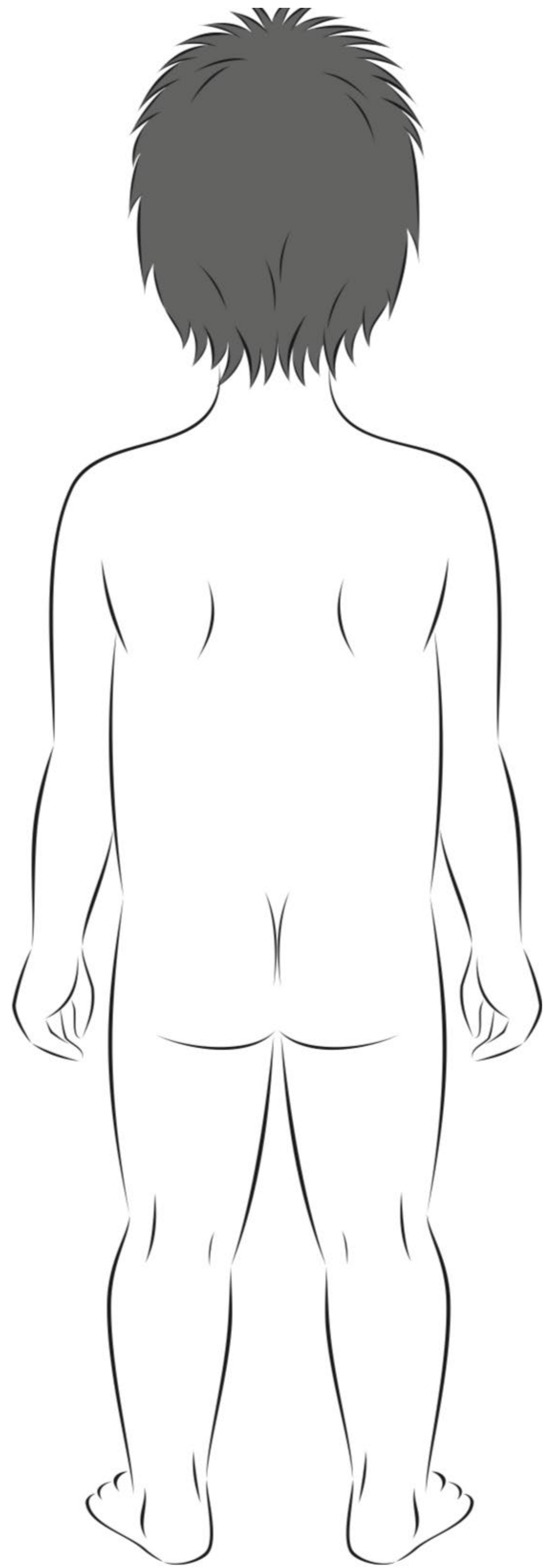
Lifestyle

____ Student ___ Home school /On line ____ Average days missed due to illness or pain ____

___ Sports/ Extracuricular activities _______________________ ____Hours or on line activity

per day ____ Phone or Tv in bedroom ____ Work outside of school ______________

___ Other ____

I am aware of HIPAA privacy guidelines. I understand my rights regarding the protections of my Child's health information (PHI). I understand that I have a right to revoke the authorizations at any time. I hereby agree to pay for the services in full.

I also understand that acupuncture treatments may involve the use of sterile one time needles, moxibustion, shonishin, acupressure, tui-na, cupping, gua-sha, aroma puncture, aromatherapy, food guidelines, and electrical acupuncture. The risks of acupuncture have been explained to me and though they are quite rare they may include infection, or puncturing the chest or abdominal cavity.

The duration of treatment vary from person to person depending on their specific state of health. I understand there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments.

Cancellation / No show policy- a 24 hour notice is asked for all cancelled appointments. If a 24 notice is not provided or you are a no show you may be charged $ 90.00.

Parent or Legal Guardian Signature: ____

Date _______________________________