Boulder Family Acupuncture

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Pediatric Intake Form

Patient's name: _____Date of first visit: _____

Age: Date of Birth (month/day/year): _____/_____/_____ Gender: ____ female ____ male

Mother's name: _____Father's name:_____

Address: _____City:_____ Zip: _____

Phone # (home): (_____)_____ Parent's work/cell phone # (_____)_____

Parent's e-mail address: _____

Child's GP or Pediatrician: _____

Current health concerns: _____

_____

MEDICAL HISTORY

Chicken pox _____ Scarlet fever _____ Roseola _____ Mononucleosis _____ Measles _____ Pneumonia _____Strep throat _____ Impetigo_____ Mumps _____ Whooping Cough _____ Ear Infections_____ Rubella _____ Rheumatic fever_____ other (please list) _____

_____

What screening tests has your child had? (blood, hearing, vision, etc)_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

_____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathics, etc.)

_____

_____

Please list any past prescription medications: _____

_____

IMMUNIZATIONS

MMR _____ Polio _____ Prevnar _____ Chicken Pox _____ H. Influenza B _____ DTaP _____ Influenza _____ Hepatitis B _____ Hepatitis A _____ Other: _____

Any adverse reactions to vaccines:____ yes ____ no If yes, please describe:_____

_____

FAMILY HISTORY

Heart disease _____ Diabetes_____ Birth abnormality _____ Celiac disease _____ Hypertension _____ Arthritis ___Tuberculosis ___ Eczema_____ Cancer _____Allergies _____ Mental illness _____ Asthma_____ Other: _____

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth? _____ Mother's health during pregnancy? _____

Were any of the following experienced during pregnancy?

Bleeding ____ Physical or emotional trauma ____ High blood pressure____Nausea/Vomiting_____
Cigarettes, alcohol, drug consumption ____ Thyroid problems_____ Illnesses _____ Surgery____
Medications ____ Gestational diabetes____ Depression/Anxiety____ Other_____

CHILD'S BIRTH HISTORY

Term: □ Full □ Premature: _____ weeks ____ Late: _____ weeks Weight at birth:_____lbs, ____ oz.

Length of labor _____ Any complications?_____

_____

Birth: ____ vaginal ____ C-section ____ Induced ____ Forceps ____ Suction ____ Anesthesia used

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

Birth abnormality_____ Birth injuries_____ Blue baby____ Cerebral palsy____ Seizures____ Jaundice____ Colic ____ Fever____ Rashes____

Other (explain): _____

FEEDING

Breastfed? ____ yes____ no How long?_____ Formula? ____ yes ____ no If Yes, type of milk:_____

Child's sleep patterns _____

How would you describe your child's temperament?_____

Food or environmental sensitivities or allergies (if known) _____

_____

Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Age began solids _____Which foods?_____

Typical daily diet: _____

_____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

Hives ____	Sleep problems ____	Easy bruising ____	Frequent colds ____
Burning of urine ____	Acne ____	Motion/car sickness____	Bleeding tendency ____
Bloody urine ____	Anemia ____	Diarrhea ____	Unusual fears____
Eczema ____	Night sweats ____	Earaches/Infections___	Wheezing ____
Frequent urination ____	High fevers ____	No appetite ____	Joint pains ____
Cries easily ____	Stomach aches ____	Sore throats ____	Excessive fatigue____
Bleeding gums ____	Sensitive to light____	Constipation ____	Cough ____
Heart murmur ____	Chronic rash ____	Nightmares ____	Dizzy spells ____
Nervous ____	Jaundice ____	Headaches ____	Hair loss ____
Nose bleeds ____	Body/breath odor____	Gas ____	
Vomiting spells ____	Hearing loss ____	Canker sores ____	

Other: _____

Please explain briefly what you would like to see as a result of acupuncture treatments?

_____