Russell Acupuncture

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This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to any person without your authorization.

PEDIATRIC INTAKE FORM (Ages 0 – 12)

Child's Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Cell: _____ Occupation: _____

Father's Name: _____ Cell: _____ Occupation: _____

Phone (Home): _____ Email: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Emergency contact: _____ Phone: _____ Relation: _____

Who is filling out this form? _____

With whom does the child live? _____ # of siblings: _____

Has your child ever had a massage and/or acupuncture treatment before? Yes ☐ No ☐
If yes, where and when? _____

Other health care professionals the child is seeing (ie. *Medical Doctor, Pediatrician, Chiropractor, other*)

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

How where you referred? _____

Health Concerns

Please list your child's health concerns in order of importance:

_____

_____

_____

Signature (person filling out this form): _____ Date: _____

Name of Child: _____

Medical History

Was your child adopted? yes ☐ no ☐ If yes, at what age? _____ What country? _____

List any injuries and/or major surgery your child has had and when they happened:

_____
_____
_____
_____

Has your child ever experienced any of the following?

☐ Rubella
☐ Mumps
☐ Measles
☐ Chickenpox
☐ Whooping cough
☐ Scarlet Fever
☐ Polio
☐ Rheumatic fever
☐ Diaper Rash
☐ Cradle cap
☐ Diarrhea
☐ Constipation
☐ High fevers
☐ Bedwetting
☐ Strep throat
☐ Frequent colds
☐ Stomach aches
☐ Headaches
☐ Heat or cold intolerance
☐ Ear infections:
How many? _____
How often? _____
☐ Other illnesses/diseases:
_____

Vaccinations

☐ DPT (Diptheria, Pertusis, Tetanus)
☐ MMR (Measles, Mumps, Rubella)
☐ Chickenpox
☐ Polio
☐ Flu shot
☐ Hepatitis A
☐ Hepatitis
☐ Other: _____

Did your child experience any adverse effects from vaccinations? If yes, please explain:

_____
_____

Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

_____
_____
_____
_____

Does your child have any medical allergies or sensitivities? Please list.

_____
_____
_____
_____

Name of Child: _____

Family History

Please **mark** if any close relative had any of the following health concern(s).

	Mother	Father	Brother	Sister	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather
Allergies								
Diabetes								
High Blood Pressure								
Stroke								
Heart Disease								
Cancer								
Seizure								
Hepatitis								
Kidney Disorder								
Thyroid Disorder								
Emotional Disorder								
Systemic Lupus								

Prenatal Health and History

	Health at conception	Health throughout pregnancy	Age at time of child's birth	# of previous pregnancies
Mother	Poor Fair Good Excellent	Poor Fair Good Excellent		
Father	Poor Fair Good Excellent	Poor Fair Good Excellent		

Did the mother experience any food cravings/aversions during pregnancy? Yes ☐ No ☐ If yes, please list:

_____

Did the mother receive medical care during pregnancy? Yes ☐ No ☐ Unknown ☐

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Nausea ☐ Physical/Emotional trauma
☐ Vomiting ☐ Thyroid problems ☐ Other: _____
☐ High Blood Pressure ☐ Diabetes

Where any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Chorionic villi sampling ☐ Triple screen
☐ Amniocentesis ☐ Maternal serum screening ☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Vitamins or and/or supplements: _____

Name of Child: _____

Health and Development

At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____

Where there any difficulties associated with teething? _____

Has your child experienced any pubertal changes? _____

Nutritional History

How is/was your infant fed? ☐ Breast fed ☐ Formula: Mild/Soy/Other: _____

For how long? _____

Did your infant experience any reactions to the breast mild or formula? Yes ☐ No ☐

If yes, please explain: _____

What foods were introduced **before 6 months**? Please list the approximate month and any reactions.

_____

_____

_____

Has your child ever experience colic? Yes ☐ No ☐

If yes, how severely? ☐ Mild ☐Moderate ☐ Severe

At what age and for how long? _____

Does your child have any food allergies or intolerances? Please list.

_____

_____

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)? _____

Does your child have any aversions to any foods? _____

Does your child have any environmental allergies or sensitivities? Please list.

_____

_____

Sleep Patterns

What time does your child usually go to bed? _____ Wake in the morning? _____

Does your child nap during the day? Yes ☐ No ☐ What time(s)? _____

Does your child have nightmares? Yes ☐ No ☐ How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

Social Patterns

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other: _____

What grade level? _____

Name of Child: _____

How would you describe your child's behavior at school? _____
_____
_____

How would you describe your child's behavior at home? _____
_____
_____

Does your child make friends easily? Yes ☐ No ☐

What are your child's interest & favorite activities? _____
_____

Is your child physically active regularly? Yes ☐ No ☐ How much & how often? _____
_____

Does your child have any habits (e.g. thumb sucking)? _____
_____

Does your child have any fears? _____

Approximately how much television does your child watch? _____ hours/day.

Does your child play on the computer or video games? Yes ☐ No ☐ If yes, _____ hours/week.

How often does your child read (not for school) or How often does someone read to your child?

☐ Daily ☐ Several times a weeK ☐ Weekly ☐ Less than weekly

Environment

Are there any pets in the home? Yes ☐ No ☐ What type and how many? _____

Does anyone in the child's household smoke? Yes ☐ No ☐

How is the child's home heated? _____

Do you use humidifiers in your home? Yes ☐ No ☐

How would you describe the emotional climate of the child's home? _____
_____
_____

Has your child ever had any significant physical or emotional traumas?_____
_____
_____

Signature (person filling out this form): _____ Date: _____

THANK YOU