Mountain Spirit Acupuncture

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Pediatric Intake Form

Name:_____ Date:_____
(First) (Middle) (Last)

Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Current Age: _____ Gender: _____

Mother's Name: _____ Father's Name: _____

Home Phone:_____ Parent's Cell Phone:_____

Parent's Email:_____

Emergency Contact:_____ Telephone:_____ Relationship:_____

Whom may we thank for referring you to us? _____

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally, and emotionally. Please Complete the following questionnaire as thoroughly as possible.

Is your child currently receiving health care? [Yes] [No]

If yes, where and from whom?_____

If no, when and where did you last receive health care?_____

For what reason?_____

Please identify below the health concerns that have brought you to the clinic:

Condition Past Treatment

1_____

2_____

Primary Health Concern:

When condition began: _____ Have you had this in the past? [Yes] [No]

Is your condition: [ ] Getting worse [ ] Staying Constant [ ] Coming & Going

What makes it better?_____

What makes it worse?_____

What diagnosis have you been given?_____

What kinds of treatment have you tried?_____

Secondary Health Concern:

When condition began: _____ Have you had this in the past? [Yes] [No]

Is your condition: [ ] Getting worse [ ] Staying Constant [ ] Coming & Going

What makes it better?_____

What makes it worse?_____

What diagnosis have you been given?_____

What kinds of treatment have you tried?_____

Height:_____ Weight:_____ Blood Pressure: _____/_____

Is today's visit due to Motor Vehicle Collision? [Yes] [No] When? _____

Does your child have any chronic infectious disease? [Yes] [No]
If yes, please explain:_____
Is your child suffering from any chronic illnesses? [Yes] [No]
If yes, please explain:_____

Significant diseases, injuries, hospitalizations, surgeries, X-Rays/CAT scans/MRI's/ NMR's/etc
Reason When Results (if applicable)

_____
_____
_____

Please list any prescription medications, over-the-counter medications, vitamins, or supplements that your child is currently taking:

Medication/Vitamin/Supplement Dosage Frequency Reason

_____
_____
_____

Please list any past prescription medications: _____
_____

Please list any foods, drugs, substances, or medications your child is hypersensitive or allergic to:
_____

Immunizations (please circle any that your child has had):
Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B Influenza
Prevnar Chicken Pox Others: _____
Any adverse reactions to vaccines? [Yes] [No] If yes, please describe: _____

Family History	Mother	Father	Brother(s)	Sister(s)
Age [if living]				
Health [G=good, P=poor]				
Age at death [if deceased]				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Astham				
Birth Abnormality				
Cancer				
Celiac Disease				
Diabetes				
Eczema				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Mental Illness				

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]

[Depression/Anxiety] [Thyroid problems] [Illnesses] [Gestational diabetes]

Consumption of: [Cigarettes] [Alcohol] [Drugs]

Surgery _____ Medications _____

Other_____

Child's Birth History -

Term: [Premature] ____ weeks [Full] [Late] _____ weeks

Length of labor _____ Any complications?_____

_____

Delivery: [Vaginal] [C-section] [Induced] [Forceps] [Suction] [Anesthesia used]

At birth: Weight _____lbs. _____ oz. Height _____ inches

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: _____

Feeding & Development -

Breastfed? [Yes] [No] If yes, how long? _____ Reason discontinued _____

Formula? [Yes] [No] If yes: [cow's milk] [soy] [other] _____

Age began solids _____Which foods?_____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

Age your child: Cut their first tooth _____ Lost their first tooth _____

Any deviations off of the standard expected growth chart for height/weight? [Yes] [No]

If yes, please describe: _____

How would you describe your child's temperament? _____

Energy and Immunity – please circle any that apply

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue

Catch Colds Easily Suppressed Immune System History of Antibiotic Usage

Head, Eye, Ear, Nose & Throat - please circle any that apply

Glasses Eye Strain Eye Pain Red / Itchy Eyes See Floating Black Spots Night Blindness

Ear Ringing Poor Hearing Ear Aches Headaches / Migraines Concussions Mouth Sores

Swollen Glands Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Dry Mouth

Teeth Problems Gum Problems Hay Fever/Allergies Other _____

Respiratory - please circle any that apply

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough

Asthma Bronchitis Difficulty Breathing When Lying Down Other:_____

Genito-Urinary Tract - please circle any that apply

Nighttime Urination History of Kidney Stone Other: _____

Urine Color: Normal / Clear / Dark Yellow / Reddish / Cloudy

Urine Flow: Scanty / Has Odor / Burning / Painful / Difficult / Urgent

Gastrointestinal - please circle any that apply

Nausea/Vomiting Epigastric Pain Abdominal Pain Heartburn Gas/Bloating

Low Appetite Large Appetite Bad Breath Fatigue After Eating

Stools: Hard Soft Formed Loose Sticky Black Blood Mucus Undigested Food

Floats Sinks Frequency of Bowel Movements _____ X [Day] [Week]

Sleep -

# of Hours of nighttime sleep:_____ Fall asleep _____ AM / PM Wake up _____ AM / PM

Naps: [Yes] [No] If yes, what time and for how long? _____

Difficulty Falling Asleep Why?_____

Difficulty Staying Asleep Waking When? _____ For How Long? _____

Dreams [Yes] [No] Sleep Quality [Good] [Poor] Wake Feeling Rested [Yes] [No]

Lifestyle -

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

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

c. Quantity of Fluids Consumed Daily: Water _____ Other _____

d. Exercise – Type: _____ How Often: _____

e. Approximate TV/Computer/Electronics hours per day: homework _____ play _____

f: Other _____

If your child has begun or gone through puberty please continue. If not, then you are done.

Female Reproductive - please circle any that apply

Age of first period _____ Date last period began _____ Date of last PAP _____

Average number of days of flow _____ Average number of days in cycle _____

Is menses regular? [Yes] [No] The flow is: [ ] Heavy [ ] Normal [ ] Light

Average # of tampons/pads used per day: 1st___ 2nd___ 3rd___ 4th___ 5th___ 6th___ 7th___

The color is: [ ] Fresh Red [ ] Dark Red [ ] Pale Red [ ] Purple [ ] Brown [ ] Other

Do you have the following menstruation related signs/symptoms?

[ ] Bleeding Between Cycles [ ] Nausea

[ ] Breast distension/tenderness [ ] PMS

[ ] Heavy vaginal discharge between periods [ ] Cramps

[ ] Pelvic Pain [ ] Blood Clots

Sexually active [Yes] [No] Pregnant / possibility of pregnancy? [Yes] [No] # of Weeks ___

Male Reproductive - please circle any that apply

Premature Ejaculation External Genitalia have Sensations of: Cold / Numbness / Pain / Swelling

Erectile Dysfunction Prostate Problems Sexually active [Yes] [No] Other: _____