CELINA LYONS M.Sc. R.Ac. L.Ac. ACPUNCTURE & MEDICAL ARTS

Pediatric Intake Form

Welcome to the clinic, thank you for taking the time to fill out this form.
(All information is strictly confidential.)

Date_____

Patient (Child's) Name _____

Parent / Guardian Name _____

Street Address _____ City _____Postal Code _____

Parent's / Guardian's Home Phone (____)_____ Mobile Phone (____)_____

Email _____ Birth Date _____ Age _____ Gender _____

Referred by: _____

Emergency Contact Home Phone (___)_____ M.D./Pediatrician's (____)_____

Name(s)_____ Date of last visit _____

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged the full price of your visit.

I, _____ understand the cancellation policy.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Relationship _____ Office/cell phone _____

Phone (____)_____

Phone (____)_____

Relationship _____

Reason for office visit _____ _____

Phone_____ Referred by _____

Has your child been seen by another practitioner for this? ___ Yes ___ No If yes, what was the outcome?
_____ _____
_____ _____

Has your child had acupuncture or other holistic/natural treatment before? If so, for what reason and what type of treatment? _____
_____

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(Tick in the first ___ for Past issues and in the second ___ for current issues.)

- __ __ dry skin __ __ itching __ __ cradle cap __ __ rashes, hives, eczema or psoriasis
- __ __ acne
- __ __ edema
- __ __ seizures
- __ __ bedwetting
- __ __ frequent urination
- __ __ blood clotting disorders
- __ __ urinary tract infections
- __ __ insomnia / nightmares
- __ __ anxiety
- __ __ often feel afraid
- __ __ night sweating
- __ __ ADD/ADHD
- __ __ behavioral problems
- __ __ learning problems
- **past current**
- __ __ irregular periods
- __ __ abnormal bleeding
- __ __ frequent colds
- __ __ sinus infection
- __ __ production of phlegm
- __ __ cough
- __ __ cough with blood
- __ __ reoccurring ear infections
- __ __ hay fever or allergies
- __ __ nose bleeds
- __ __ asthma
- __ __ bronchitis
- __ __ pneumonia
- __ __ hoarse voice
- __ __ difficulty swallowing

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- __ __ recurring sore throat
- __ __ frequent swollen glands
- __ __ mouth ulcers
- __ __ grinding teeth
- __ __ eye glasses
- __ __ difficulty hearing
- ___ jaundice as a baby __ abdominal bloating __ abdominal pain __ decreased appetite __ belching
- __ indigestion __ heartburn __ bad breath __ bleeding gums __ constipation __ frequent diarrhea __ blood in stools/black __ pus in stools
- __ hemorrhoids __ rectal pain __ change in appetite __ colic __ low energy / fatigue __ bed wetting

Female Patients: Age of menses onset: _____

Please check all that apply:

past current

- __ __ PMS
- __ __ vaginal infections

past current

__ __ breast tenderness __ __ painful periods

Family History (Complete for each family member, placing an X in the appropriate box): Child Mother Father Sister Brother

Allergies Blood Disorder / Anemia Diabetes Cancer or Tumors

Seizures High Blood Pressure Kidney or Bladder Disorder Stomach or Intestinal Disorder Drug / Alcohol Use or Abuse Tuberculosis Heart Disease Stroke Depression / Mental Illness

Age at Death

Blood Work: When was the last time your child had blood work? What lab tests were done?

_____

Vaccinations

MMR: Hep B: Chickenpox: Hib DTaP: Influenza: Pneumococcal: Polio:

Birth

What type of birth did your child have? (please check all that apply)

Home birth _____ Hospital_____ Other _____

Midwife_____ O.B. _____ Birthing Doula _____ Please describe

_____

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Please describe any medical procedures, if any, used during the birth _____
_____

Please describe any complications that may have occurred during the birth _____
_____
_____

Please describe the pregnancy of this child. Include any physical complications as well as any emotional issues/stressors that may have arisen during the pregnancy. _____
_____
_____
_____

_____ _____ _____ _____

Major Hospitalizations/Surgeries – Please list any hospitalization or surgeries your child has undergone including date of occurrence 1. _____2.
_____ 3. _____4.
_____ 5. _____6.
_____

Medicines, Herbs, Supplements (Please check any that the patient is currently taking)

___ aspirin ___ ibuprofen/motrin ___ acetaminophen (Tylenol) ___ allergy medication

___ antacids ___ fiber / laxatives ___ insulin ___ cold medicine (Dimetapp, Sudafed)

other, please list _____ _____ __

How many times has your child taken Antibiotics? ____ _____ Did you supplement with probiotics (acidophilus)? Yes _____ No _____

Please list any known medication allergies _____ _____

Diet

Is (was) your child breastfed or formula fed? _____ Breastfed only _____ formula only _____ both Until what age was she/he breastfed? _____ What brand(s) of formula have you used? _____ _____
_____ _____ Was the formula soy, cow milk, or goat milk based? _____

What was solid first introduced? _____

Please describe your child's typical daily diet: Breakfast _____ Morning Snack _____ Lunch _____

Afternoon Snack _____ Dinner _____

Evening Snack _____

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Please describe any restricted diet your child follows now or in the past:
_____ _____
_____ _____
_____ _____

Please list any known food allergies/sensitivities _____ _____ _____
_____

Please list your health concerns for your child in order of importance:

Please describe an average day of activities for your child:

Please describe the living arrangements for your child. Including circumstances such as joint custody, co-sleeping, siblings, etc.

What are your expectations and/or hopes for the outcome of this treatment?

Please provide any additional information about your child's health not covered by the above questions (if you need additional room please use the back of this paper).