

CELINA LYONS M.Sc. R.Ac. L.Ac. **ACUPUNCTURE & 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. _____ 3. _____
2. _____ 5. _____
4. _____
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).