Acupuncture Northwest

Pediatric Patient Health History

Please note that all information is confidential.

Name: birth date: / / today's date: / /

In Case of Emergency Contact:

Relationship & Phone:

Physician: Phone:

How did you hear about us?

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

What brings you here today?

What is the reason for your child's visit today?

____

____

____

How, when and where did this condition begin

____

____

____

What types of treatments have you tried, if any?

____

____

____

How does this condition impair his/her daily activities?

____

____

____

Please list the main health problems you would like to address in order of importance:

1. ____
2. ____
3. ____

Your Child's Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents (include dates):

____

____

____

How was your pregnancy with your child?:

____

____

____

How was the birth/delivery of your child? (List any procedures/complications that may have occurred):

____

____

____

How was your child as an infant?:

____

____

____

Please list any medications/vitamins/supplements your child is currently taking, as well as, medications they have taken in the past:

Medications	**Reason**	**How Long**

Please circle any of the following that are a part of your life

Mental Illness	Diabetes	Hepatitis	HIV
Seizures	Cancer	Heart Disease	Asthma
Allergies	Fatigue	Parasites	Kidney Stones
Stroke	Arthritis	Ulcers	Herpes
High Blood Pressure	Venereal Disease	Osteoporosis	AIDS
Rheumatic Fever	Thyroid Problems	Mononucleosis	Gall Stones

Other ____________________________________

Lifestyle:

What is your child’s daily diet like?

Breakfast:

____

Lunch:

____

Dinner:

____

Snack:

____

Are there any dietary restrictions for your child and/or ways of specific ways of eating in your family?

____

____

____

What are your child's favorite activities?

____

____

____

How much exercise does your child get per week? ____________________________

Type of exercise:

____

Do your child have trouble falling asleep? Yes No

Time to bed: ___________ Time to rise: ___________

How many hours of sleep does he/she get per night? ___________

Is he/she rested in the morning? Yes No

Does she/he wake during the night? Yes No

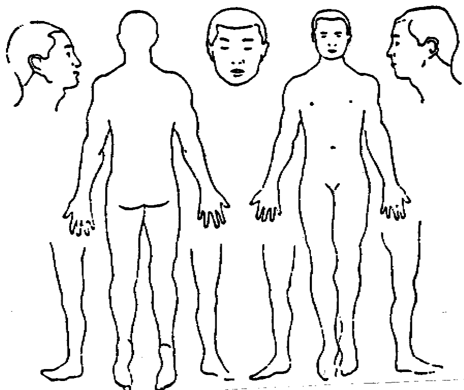
How is your home Life?

____

____

____

Please mark all areas of pain on the diagram:



Systems Review (please circle all that apply):

0 = never 1 = rarely 2= occasionally 3= frequently 4 = always

0 1 2 3 4	spontaneous sweat	0 1 2 3 4	fatigue
0 1 2 3 4	allergies	0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma	0 1 2 3 4	shortness of breath
0 1 2 3 4	general weakness	0 1 2 3 4	cough
0 1 2 3 4	dry nose/mouth/skin/throat	0 1 2 3 4	nasal discharge
0 1 2 3 4	feel worse after exercise	0 1 2 3 4	sinus congestion

---

0 1 2 3 4	nightmares		
0 1 2 3 4	feel heart beating	0 1 2 3 4	chest pain
0 1 2 3 4	insomnia	0 1 2 3 4	feel low in spirits
0 1 2 3 4	sores on tip of tongue	0 1 2 3 4	headaches
0 1 2 3 4	anxiety	0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder		

overall body temperature high med low

---

0 1 2 3 4	digestive problems	0 1 2 3 4	prone to worry
0 1 2 3 4	low appetite	0 1 2 3 4	ravenous appetite
0 1 2 3 4	loose stools	0 1 2 3 4	acid reflux
0 1 2 3 4	mouth sores	0 1 2 3 4	fatigue after eating
0 1 2 3 4	gas/bloating after food	0 1 2 3 4	bruise easily
0 1 2 3 4	gums (bleeding/swollen)	0 1 2 3 4	thirst
0 1 2 3 4	organ prolapsed (diagnosed)	0 1 2 3 4	belching/vomiting
0 1 2 3 4	often sick or have allergies	0 1 2 3 4	crave sweets

0 1 2 3 4	Tired after meals	0 1 2 3 4	pain worse w/ rain
0 1 2 3 4	fibrocystic breasts	0 1 2 3 4	overweight
0 1 2 3 4	acne	0 1 2 3 4	heavy sensation
0 1 2 3 4	foul smelling stools	0 1 2 3 4	dizziness

---

0 1 2 3 4	dry mouth/throat	0 1 2 3 4	excessive sweating
0 1 2 3 4	thirsty for cold drinks	0 1 2 3 4	red acne
0 1 2 3 4	do you feel warm	0 1 2 3 4	short menses cycle

---

0 1 2 3 4	symptoms worse with stress	0 1 2 3 4	irritable
0 1 2 3 4	breast tenderness	0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest	0 1 2 3 4	dry eyes
0 1 2 3 4	alt. diarrhea/constipation	0 1 2 3 4	ear ringing
0 1 2 3 4	muscle twitches/spasms	0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension	0 1 2 3 4	red eyes
0 1 2 3 4	feel better after exercise		

0 1 2 3 4	dry skin	0 1 2 3 4	scanty menses
0 1 2 3 4	brittle nails	0 1 2 3 4	late menses
0 1 2 3 4	dizziness/lightheaded	0 1 2 3 4	see floaters
0 1 2 3 4	loosening or thinning hair		

---

0 1 2 3 4	premature grey hair	0 1 2 3 4	Morning diarrhea
0 1 2 3 4	sore, cold or weak knees	0 1 2 3 4	feel cold

0	1	2	3	4	low back pain		0	1	2	3	4	edema
0	1	2	3	4	frequent urination		0	1	2	3	4	urinary incontinence
0	1	2	3	4	Night sweats		0	1	2	3	4	ear problems
0	1	2	3	4	Hot Flashes		0	1	2	3	4	pain better with heat
0	1	2	3	4	face flush		yes		no			impaired memory
0	1	2	3	4	heat in palms or soles		yes		no			infertility
0	1	2	3	4	afternoon fever		yes		no			hair loss
							high		normal		low	libido

Urination: Please circle any of the following symptoms you are currently experiencing

Burning Urgent Retention Scanty

Profuse Dribbling up to urinate more than 1x a night

Bowel Movement:

Frequency: When? ______________ Feels complete? Yes No

Consistency: Well-formed Hard Loose Alternates

Stools: Undigested food Blood Mucus

Diseases/Disorders:

____

____

Chronic or continuing illnesses:

____

____

Has your child ever experienced any major traumas? Y / N

Please explain:

____

____

____

Is there anything else I should know?

____

____

____

Signature: ________________________________

Date: ________________________________