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Acupuncture & Chinese Herbal Medicine

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Pediatric Health History

Today's date _____

Child's Name _____

Nickname _____

Name(s) of Primary Caretaker(s) _____

Caretaker's Relationship to Child _____

Age _____ Date of Birth _____

Height _____ Weight _____

Gender _____

Place of Birth _____

Address _____ City _____

State _____ Zip _____

Caretakers Phone (H) _____ (W) _____

Caretakers Email Address _____

Family Physician _____ Referred By _____

Emergency Contact _____ Phone _____

Has your Child Been Treated By Acupuncture or Oriental Medicine Before Yes No

Main Problem(s) that your child would like help with:

How long ago did this problem begin (be specific)?

To what extent does this problem interfere with your child's daily activities (school, sleep, etc)?

Has your child been given a diagnosis for this problem: If so, what?

What kinds of treatment has your child tried?

Past Medical History :

Complications during gestation or birth _____

Does your child have all recommended immunizations? Yes No

If no, list immunizations your child does not have _____

Any reactions to immunizations? _____

Surgeries (type of and date) _____

Significant Trauma (auto accidents, falls, etc)

Significant Dental Work (type and date) _____

Allergies (drugs, chemicals, foods/result) _____

Medicines taken within the last two months (drugs, vitamins, herbs, supplements, etc):

Name of Medication/Supplement

Reason for Taking It

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has your child taken many courses of antibiotics over her/his life? If yes, for what reasons?

Does your child wake at night? _____

Would you say your child's appetite is good _____, **medium** _____, **small** _____

Is your child a choosy eater? In what ways? _____

Has your child ever been on a **restricted diet**? Yes No What Kind? _____

Please describe your child's **average daily diet**:

Morning _____

Afternoon _____

Evening _____

Does your child suffer from any of the following?:

General

- Fevers
- Sweat easily
- Sweating after feeding
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Strong thirst (cold or hot)
- Sudden energy drop - what time of day? _____
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Glasses
- Poor vision
- Eye pain
- Color blindness
- Discharge from ears
- Frequent ear infections
- Earaches
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions

- Poor hearing
- Nose bleeds
- Facial pain
- Tonsillitis
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when _____

- Other head or neck problems _____

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____

Respiratory

- Cough
- Bronchitis
- Production of phlegm what color _____
- Coughing blood
- Pneumonia
- Asthma
- Other lung problems _____

Approximately when was your child's last cold or flu? _____

Gastrointestinal

- Colic
- Nausea
- Constipation
- Black or green stools
- Bad breath
- Abdominal pain or cramps
- Vomiting
- Gas

- Swollen abdomen
- Blood in stools
- Diarrhea
- Belching
- Teething problems
- Other stomach or intestinal problems _____

Genito-urinary

- Pain on urination
- Blood in urine
- Leakage in the day
- Bedwetting
- Does your child wake up to urinate? Yes No.
How often?

- Any particular color to your child's urine? _____
- At what age was your child toilet-trained? _____
- Has your child started her menses yet? _____
- Does she have any menstrual difficulties or irregularities? _____

- Other genital or urinary system problems _____

Musculoskeletal

- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

Neuropsychological

- Seizures
 - Areas of numbness
 - Bad temper
 - Difficulty concentrating
 - Vacant
 - Moody
 - Aggressive
 - Temper tantrums
 - Dizziness
 - Lack of coordination
 - Depression
 - Loss of balance
 - Anxiety
 - Developmental disability
 - Late developer
 - Other neurological or psychological problems
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Comments (please mention any other problems you would like to discuss):

Indicate painful or distressed areas:

