Sound View Acupuncture and Chinese Herbs

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Today's date _____

Name_____ Nickname_____

Name(s) of Primary Caretaker(s) _____

Caretaker's Relationship to Child_____

Age _____ Date of Birth _____

Height _____ Weight _____

Place of Birth _____ SS # _____

Phone (H) _____ (W)_____

Address _____ City _____ State _____ Zip _____

Email Address _____

Would you like a reminder before the appointment?_____ email or phone reminder? (circle one)

Family Physician _____ Referred By _____

Emergency Contact _____ Phone_____

Has You 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 :

Problems with pregnancy or birth_____

Does your child have all recommended immunizations? _____

Any reactions to immunizations? _____

Surgeries (type 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 _____

Comments (please mention any other problems you would like to discuss):

_____

_____

_____

_____

Indicate painful or distressed areas: