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Pediatric Intake Form

Who are you?

Name:______________________________________
Gender: M F
Age:____________
Date of Birth:________________________________
Current Weight:____________

Parent's Names:____
Address:____
Postal Code:____
Phone Number:(___)_____________________
Who does the child live with:____
Emergency Contact:______________________ Phone Number:_______________

Does the child have a medic alert?____
Or life threatening allergies?____

What's going on?

What is the main health concern?____
When did this begin?____
How long has this gone on for?____
What other treatments have been attempted?______________________________
____
What was the result with these treatments?_______________________________
____
What factors may be contributing to this problem?_________________________
____

What have you had? Circle all applicable:
Chicken Pox
Measles
Mumps
Rubella
Surgery
Allergies

Vaccinations: Check all applicable
D-PTP (Diphtheria, Pertussis, Tetanus,

Polio)
Hib (H. influenza, often given with D-PTP)
MMR (Measles, Mumps, Rubella)
Td + P (Tetanus, Diphtheria, Polio)
OPV (oral polio vaccine) Hepatitis B
Flu shot

Have you ever been to the emergency room?______________________________
What was it for?____

What are you taking?
Please list any medications you have taken in the past and the ones you are presently taking.____
____

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking.
____
____

How was your birth?
During the pregnancy were you exposed to any of the following:
Alcohol
Cigarette smoke
Recreational drugs
Prescription medications
Over the Counter drugs
Herbal preparations
Ultrasound
Amniocentesis
Illness
Large amount of stress

Were there any complications during the pregnancy?
Nausea
Hypertension
Vomiting
Preeclampsia /Eclampsia
Bleeding
Placenta Previa
Gestational Diabetes
Maternal Rubella
Maternal Chicken Pox

Maternal Cytomegalovirus
Maternal Toxoplasmosis
Other

At Birth:
Weight:________
Length:________
Were you term?_______ pre-term? ______ post-term?______ premature?_____
Where did the birth take place? Home Hospital
What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth?
Difficult delivery
Breech delivery
Long 2nd stage of labour
Shoulder dystocia
Forceps or suction used
Other
What were the APGAR scores?____
Were any interventions administered at birth? Vitamin K Eye drops
What were your mother's feelings about the birth?__________________________

As a Newborn:
Did you have any of the following conditions?
Jaundice
Colic
Hip displacement
Meningitis
Scoliosis

What do you like to eat?
As a baby were you breastfed? Yes No For how long?________________
Were you fed formula? Yes No
What kind of formula was used?____
Were there any reactions to the formulas?________________________________
How old were you when were you introduced to food?_______________________
What did you eat first?____
Were their any reactions to any foods?___________________________________

What do you eat now?____
What are your favorite foods?____
What foods do you like the least?_______________________________________
Do you exclude any foods for religious, ethical or ethnic

reasons?____
____

Where do you live?
What kind of a building do you live in (house, apartment, etc.)?_______________
How old is the building?____
Has it been renovated recently?____
Does your home have carpet?____
Has there ever been a problem with mildew in the home? ___________________

What is your family like?
Has anyone in your family had any of the following diseases? If yes, please indicate who.
Cancer
Diabetes
Heart Disease
Stroke
Hypothyroidism
Arrhythmia
Rheumatoid Arthritis
Hyperthyroidism
High blood pressure
Lupus Sickle-cell anemia
Crohn's Disease
An Autoimmune disease
Irritable Bowel Syndrome
Ulcerative Colitis

What do you like to do?
Do you go to school? Which one?____
Do you go to daycare?____
Do you have a nanny?____
How do you like playing with other kids?____________________________________
Do you have a pet?____
Do you watch TV? Yes No How often?___________________
Do you play video games? Yes No How often?___________________
Do you play on the internet? Yes No How often?___________________
Do you have family time? Yes No How often?___________________
Do you get exercise? Yes No
What do you like to do for exercise?_______________________________________
What else do you like to do?____

How is your sleep?
What position do you like to sleep in?_____________________________________

How long do you sleep at night?____
How long does it take you to fall asleep?_____________________________________
Do you wake up during the night?____
Do you have nightmares?____
How do you feel when you wake up?____
Are you rested?____
Do you take naps?____
How long are your naps?____
What is your energy like during the day?_____________________________________

From Head to Toe: Please check all that apply.
Cradle cap (seborrheic dermatitis)
ADHD/ ADD
Eczema
Urinary incontinence
Diaper rash
Bedwetting
Yeast infection
Fecal incontinence
Impetigo
Seizures
Conjunctivitis
Paralysis
Scabies
Cerebral Palsy
Sinusitis
Spina bifida
Ear infections
Cystic Fibrosis
Chronic Colds
Chronic Diarrhea
Croup Appendicitis
Bronchitis
Constipation
Asthma
Chronic Abdominal pain
Pneumonia
Short stature
Cardiovascular problems
Other

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Office Policies

Fees
<u>Acupuncture and Moxibustion Therapies</u>
Initial Visit, consultation, diagnosis and treatment: $150
Follow-up Visits: Adults: $90; Children: $45

<u>Herbal Therapies</u>
Adult: Most herbal therapies $45 a week
Children: $25 per week

Making Appointments: For healing to be most effective, a series of visits is usually necessary. We advise that you schedule in advance to ensure continuity of appointments.

Cancellation Policy: Missed appointments without prior notification is subject to a full visit fee. If possible, please provide a 48-hour advance cancellation notice so that we may staff the office properly and that other patients can be helped in that time slot.

Payment Policy: We charge for services provided. Payment is due at the time of service. We accept cash, checks, Visa, Master Card, American Express and Discover. Returned checks are charged a $10 fee.

Insurance: We provide a Superbill, which contains the information you need to submit a claim for reimbursement to your insurance carrier. Please check with your insurance carrier to determine if acupuncture is covered under your plan. Payment is due at the time of services. Please note we do not know of any herbal therapies that are covered under insurance at this time.

Childcare Policy: We do not offer childcare in the clinic. However, we are a child-friendly practice. Please do not leave children unattended if they are very young or may become disruptive.

Change of Address: Please notify us when your address or phone number changes as soon as possible.

Mobile Phones: Please turn off your cell phones before entering treatment rooms.

______________________________	______________________
Patient Name (Please Print)	Relationship to Patient
______________________________	______________________
Patient Signature (or Guardian if Patient is a minor)	Date