Health History

Reason for office visit:_____

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 treatments before? If so, for what reason and what type of treatment?
_____
_____

Please check off any of the following symptoms that your child has in the past or is currently experiencing:

past current	past current	past current
__ __ frequent colds	__ __ jaundice as a baby	__ __ dry skin
__ __ sinus infection	__ __ abdominal bloating	__ __ itching
__ __ production of phlegm	__ __ abdominal pain	__ __ cradle cap
__ __ cough	__ __ cough with blood	__ __ decreased appetite
__ __ re occurring ear infections	__ __ rashes, hives, eczema or psoriasis	__ __ belching
__ __ indigestion	__ __ hay fever or allergies	__ __ acne
__ __ heartburn	__ __ edema	__ __ nose bleeds
__ __ bad breath	__ __ seizures	__ __ asthma
__ __ bleeding gums	__ __ bedwetting	__ __bronchitis
__ __ constipation	__ __ frequent urination	__ __ pneumonia
__ __ frequent diarrhea	__ __ blood clotting disorders	__ __ hoarse voice
__ __ blood in stools/black	__ __ urinary tract infections	__ __ hemorrhoids
__ __ difficulty swollowing	__ __ pus in stool	__ __ hemorrhoids
__ __ insomnia / nightmares	__ __ recurring sore throat	__ __ rectal pain
__ __ anxiety	__ __ frequent swollen glands	__ __ often feel afraid
__ __ mouth ulcers	__ __ change in appetite	__ __ night sweating
__ __ grinding teeth	__ __ colic	__ __ ADD/ADHD
__ __ eye glasses	__ __ low energy / fatigue	__ __ difficulty hearing
__ __ bed wetting	__ __ learning problems	__ __behavioral problems

Female Patients: Age of menses onset: _____
Please check all that apply: past current past current past current __ __ PMS __ __ breast tenderness ___ irregular periods ___ vaginal infections ____painful periods ___abnormal bleeding___

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/Tumors					
Seizures					
High Blood Pressure					
Kidney/bladder disorder					
Drug/alcohol use/abuse					
Tuberculosis					
Heart disease					
Stroke					
Depression/mental illness/anxiety					
Suicide attempt					
Age of Death					
Other Autoimmune					

Vaccinations

	Yes	No	Some	Reactions?
Hep B				
DTap				
HIB				
Polio				
MMR				
PVC				
Influenza				
Rotavirus				
Hep A				
HPV				
Meningococcal				
Varicella				

Did your child receive vaccines on an alternate schedule? Yes/No
If yes, Please explain:_____

_____

Blood Work: When was the last time your child had blood work? Which labs were done?_____

Birth

What type of birth did your child have? (Please check all that apply)
Home _____Birthing Center _____ Hospital _____ Birthing Doula _____
Midwife _____ Medical Doctor _____ Water birth _____ Other _____
Please describe _____
Please describe any medical procedures/medications, 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._____ 2._____
3. _____4._____
5. _____6._____

Medicines (Please check any that the patient is currently taking)
___ aspirin ___ antacids
___ ibuprofen/motrin ___ fiber / laxatives
___ acetaminophen (Tylenol) ___ insulin
___ allergy medication ___ cold medicine (Dimetapp, Sudafed)
Pharmaceuticals: please list with dosage:
_____
Vitamins/Supplements/Herbs/Homeopathics:_____
_____

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 _____
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?

Anything else you feel is important that wasn't covered: