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 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
____

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

____

____

____

____

Indicate painful or distressed areas: