New Pediatric Patient Health History

PATIENT INFORMATION		Today's Date:
Patient's Name:	Gender:	Date of Birth:
Parents' Names:		
Street Address:		
Home Phone:	Cell Phone: ( )	
Email Address:	May we send you emails about clinic events or newsletters? ☐ YES ☐ NO	
Parents are ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Other ________________________		

EMERGENCY CONTACT	
Emergency Contact:	Relationship:
Emergency Contact Phone: ( )	Emergency Contact Office/Cell Phone: ( )

OTHER CARE PROVIDERS	
Provider's Name:	Provider Type:
Provider's Address:	Phone:
Provider's Name:	Provider Type:
Provider's Address:	Phone:
Provider's Name:	Provider Type:
Provider's Address:	Phone:

GENERAL HEALTH

What is the primary concern associated with your visit today?

Onset: How long has your child had this/these issues?

Does anything make the condition better? ☐ YES ☐ NO If yes, what?

Does anything make the condition worse? ☐YES ☐ NO If yes, what?

Has your child been treated for this condition before? ☐ YES ☐ NO If yes, please describe.

Is your child currently being treated for any other medical problems? ☐ YES ☐NO If yes, please describe.

Are there any other issues or health concerns you are hoping to work on?

Has your child tried acupuncture before? ☐ YES ☐ NO If yes, please describe the experience and any issues.

How did you hear about the clinic? ☐ Website ☐ Another Health Care Provider ☐ Advertisement

☐ Friend ________________________________ ☐ Other ____

MEDICATIONS

Does your child have allergies to medications? ☐YES ☐NO If yes, please describe.

List any pharmaceuticals, both prescription and over the counter, that your child is currently taking:

List all herbal prescriptions and supplements your child is currently taking:

How many times has your child taken antibiotics?

DIET AND NUTRITION- Please describe your child's typical diet.
Breakfast:
Lunch
Dinner
Snacks
Does your child have any food allergies or sensitivities? If yes, please list them.

Previous Medical History

	Gets Often	Never Had	Occasionally	How often per year?
Seasonal Allergies	☐	☐	☐	
Colds/Flu	☐	☐	☐	
Ear Infections	☐	☐	☐	
Strep Throat	☐	☐	☐	
Asthma	☐	☐	☐	
Other	☐	☐	☐	

Vaccination History

Vaccine	**Fully Vaccinated**	**Partially Vaccinated**	**Not Vaccinated**
Hepatitis B (HepB)	☐	☐	☐
Rotavirus (RV)	☐	☐	☐
Diphtheria, tetanus & acellular pertussis (DTaP)	☐	☐	☐
Haemophilus influenzae type b (Hib)	☐	☐	☐
Pneumococcal conjugate (PCV13)	☐	☐	☐
Inactivated poliovirus (IPV)	☐	☐	☐
Influenza	☐	☐	☐
Measles, Mumps, Rubella (MMR)	☐	☐	☐
Varicella (VAR) - Chickenpox	☐	☐	☐
Hepatitis A (Hep A)	☐	☐	☐
Meningococcal	☐	☐	☐
Tetanus, diphtheria, & acellular pertussis (Tdap)	☐	☐	☐
Human papillomavirus (HPV)	☐	☐	☐
Meningococcal B (MenB)	☐	☐	☐
Pneumococcal polysaccharide (PPSV23)	☐	☐	☐

Has your child had any reactions to a vaccine? If so, please describe the reaction.

Child's Health History

	Yes	No
Chicken Pox	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Measles (Rubeola)	☐	☐
Whooping Cough	☐	☐
Acne	☐	☐
Anemia	☐	☐
Anger	☐	☐
Asthma/Wheezing	☐	☐
Bad foot odor	☐	☐
Bed-Wetting	☐	☐
Chronic Cough	☐	☐
Colic	☐	☐
Constipation	☐	☐
Diaper rash	☐	☐
Diarrhea	☐	☐
Dizzy spells	☐	☐
Earaches/Infections	☐	☐
Early Puberty	☐	☐
Eczema	☐	☐
Fears/Phobias	☐	☐

	Yes	No
Frequent Colds	☐	☐
Frequent urination	☐	☐
Gas	☐	☐
Growing pains	☐	☐
Headaches	☐	☐
Hearing loss	☐	☐
High fevers	☐	☐
Hives	☐	☐
Hyperactivity	☐	☐
Jaundice as a baby	☐	☐
Motion/car sickness	☐	☐
Nervous/Anxiety	☐	☐
Night Sweats	☐	☐
Nightmares	☐	☐
Nose bleeds	☐	☐
Poor Appetite	☐	☐
Sleep problems	☐	☐
Sore throats	☐	☐
Stomach Aches	☐	☐
Tantrums	☐	☐
Tooth Problems	☐	☐

Screening Tests

	Normal	Issue	Not Tested	Comments
Vision	☐	☐	☐	
Hearing	☐	☐	☐	
Speech	☐	☐	☐	
Learning Impediments	☐	☐	☐	

Family Health History

	Mother	**Father**	**Sibling**	**Comments**
Allergies (environmental)	☐	☐	☐	
Obesity	☐	☐	☐	
Diabetes	☐	☐	☐	
Cancer	☐	☐	☐	
Hypertension	☐	☐	☐	
Eczema	☐	☐	☐	

Birth and Development History			
Birth Weight	Birth Length	Born at how many weeks?	APGAR Score
Were there any complication after delivery? If so, please explain.			
Breast Fed? Yes ☐ No ☐ If yes, for how long?		If formula was used, at what age was it started?	
When were solid foods introduced?		First Foods?	
Age First Walked?	Age First Talked?	Age Developed Teeth?	

Mother's Pregnancy History		
Age at conception	Length of Labor	Vaginal Birth Yes ☐ No ☐
Was it a difficult labor? Yes ☐ No ☐ If yes, please explain		
During pregnancy, did any of these occur?	Smoking Yes ☐ No ☐	Nausea/Vomiting Yes ☐ No ☐
Preeclampsia Yes ☐ No ☐	Alcohol Yes ☐ No ☐	Emotional Stress Yes ☐ No ☐
Diabetes Yes ☐ No ☐	Coffee Yes ☐ No ☐	Recreational Drugs Yes ☐ No ☐

Other Information
Please list any other information that you feel would be helpful.

Please note that it is our policy that parents must be in the treatment room for children 12 and under, and must be on premises and available during treatments for children under 18.