on point acupuncture

Pediatric Intake Form

General Information

Today's Date: _____
Name of Child: _____
Name of Parent(s)/Legal Guardian(s): _____
Parents are (circle): Married Separated Divorced Living Together Other: _____
Address: _____ City/Zip: _____
Phone: Cell _____ Home_____
Email: _____ E-mail reminders/updates? YES/NO
I would like a reminder via (circle please): *E-mail* *Phone call* *Text*

Child's date of birth: _____ Age: _____ Gender: M F
Height: _____ Weight: _____ Grade in School: _____
Siblings Name(s)/Gender/Age: _____
_____
Child's Primary Care Provider Name/Phone: _____

How did you hear about us? *(please circle) Internet Facebook Newspaper Signage TV brochure*
Another patient or friend referral: _____
Dr referral: _____ *Other:* _____

Reasons for your visit:
(1) _____
(2) _____
(3) _____
(4) _____

What initiates the symptoms? _____
What makes them better? _____
What makes them worse? _____
Additional comments:

Health History of Child

Health Issues During First Year: _____
Child Breast Fed: Y N If Yes, for how long? _____
Age Solid Food Introduced: _____ Food/Feeding Problems: _____
_____
Age Began Crawling: _____ Walking: _____ First Teeth: _____
First Words: _____ Any Sleeping Issues: _____
Any Bowel Issues: _____

Vaccination History

MMR Age: _____ Chicken Pox Age: _____ Hep B Age: _____
Polio Age: _____ DPT Age: _____ Hib Age: _____
MCV Age: _____ HPV Age: _____ Flu Age: _____
Others: _____
Please note any adverse reactions: _____

Medications:

_____
_____
_____

General System Overview

Please Circle All That Apply:

Newborn Jaundice Cradle Cap Eczema/Psoriasis Colic

Diaper Rash Snoring Diarrhea Asthma

Chronic Sniffles Anemia Constipation Vomiting

Finicky Eating Stomach Aches Nightmares Tantrums

Growing Pains Fears/Phobia Depression Hyperactivity

Chronic Ear Infections Seizures Inattention Poor Teeth

Please describe your child's stools/frequency: _____
Hours of sleep per night/quality of sleep/frequent waking: _____
_____

Additional Comments: _____
_____
_____
_____