Acupuncture & China Medical

PEDIATRIC INITIAL CONSULTATION & PATIENT INFORMATION

All of your answers will be held **absolutely** confidential. If there is anything you wish to bring our attention which is not asked on this form, please note it in the Comments section. Thank you.

Patient's Name_____ Age_____ D.O.B._____

Address _____ City_____ State_____ Zip_____

Mother's Name and Occupation_____

Father's Name and Occupation_____

Email_____ Phone_____

Emergency Contact Person_____ Phone _____

Parents are (check one) _____ Married _____ Separated _____ Divorce _____ Other _____

Patient's Dr.'s Name_____ Phone _____

Insurance Company _____ I.D. #_____

Referred by_____ Or Yelp_____ Website_____ Facebook_____ Other_____

Has your child been treated by Acupuncture or Oriental Medicine before? _____

Main Problem(s) you would like us to help your child with _____

_____

How long ago did this problem begin (be specific)? _____

Have your child been given a diagnosis for this problem? If so, what? _____

_____

What kind of treatment have you tried? _____

Any known allergies to drugs, herbs, environment, food, etc. _____

_____

List all medications child is on now and dosages if known:

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

List all supplements child is now taking and dosage if known:

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

List all surgeries and hospitalizations, including date occurred:

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

HEALTH HISTORY OF CHILD

Gestational age of birth (week at birth)_____ Birth Weight_____ Birth Length_____

Complications after delivery: Y N If yes, please explain_____

_____

Child Breastfed: Y N For how long_____ When put on formula_____

When did child walk_____ Talk_____ Develop teeth_____

Hearing test normal: Y N Not Tested Vision test normal: Y N Not Tested

Speech Impediments: Y N Past Learning Impediments: Y N Past

VACCINATION HISTORY

Yes, has had; **No**, has not; **Some**, did not finish all shots

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some

Hib: Yes No Some Polio: Yes No Some Chicken Pox: Yes No Some

Any reactions to vaccinations? If so, please explain _____

_____

MOTHER'S PREGNANCY HISTORY

Age at Conception_____ Length of Labor_____ Vaginal Birth: Y N

Traumatic Birth: Y N If yes, please explain_____

_____

Medication during pregnancy_____

Birth interventions (check one) ____Induction ____Forceps ____Vacuum Extraction ____C-Section ____None

During pregnancy did any of the following occur?

Smoking: Y N Diabetes: Y N Nausea/Vomiting: Y N Alcohol: Y N

Emotional Stress: Y N Coffee: Y N Recreational Drug: Y N Preeclampsia: Y N

ENVIROMENTAL EXPOSURE

Has the child ever lived near a refinery, polluted area or in a house with lead paint? If so, what sort of pollution were they exposed to: _____

_____

What year was your home/apartment built? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? _____

_____

Comments: _____

_____

_____

_____

AUTHORIZETION FOR CARE OF A MINOR

I hereby authorize **Zhenyu Qiu** to administer care to my Son/Daughter as they deem necessary. I clearly understand that I have the right to refuse care and that I am personally responsible for payment of all costs associated with the treatment of care:

Parent or Guardian _____ Date _____

Witnessed _____ Date _____