

Denver Community Acupuncture

Pediatric Intake Form

All Medical Information is confidential.

I. General Information.

Name of Child: _____ Date: _____

Name of Parent(s)/Legal Guardian(s): _____

Occupation(s): _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Address: _____ City/Zip: _____

Phone: (home) _____ (cell) _____ (work) _____

Email: _____

Child's Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Sex (m/f): _____ Grade of School: _____

Child's Primary Care Provider/Contact Information: _____

Emergency contact name & phone number: _____

How did you hear about us? _____

Reasons for your visit: (1)

(2)

(3)

What initiates the symptoms? _____

What makes them better? _____ What makes them worse? _____

Additional comments:

II. Pregnancy and Birth

Child is yours by (circle): Birth Adoption Stepchild Other: _____

Mother's age at conception: _____ Did she have other children already? _____

Health during pregnancy (circle all that apply):

Smoking Preeclampsia Vaginal Birth Coffee Birth
Recreational Drugs Diabetes Nausea/Vomiting Traumatic Emotional Stress

Location of birth: _____

If the birth was difficult, please explain: _____

Describe any interventions at birth including caesarean section and/or use of anesthesia: _____

Health of baby at birth: _____

Gestational age at birth: _____ Birth weight: _____ Birth length: _____

Additional Comments:

III. Health History of Child

General Information.

Health issues during newborn period: _____

Child breast fed (circle): Yes No If yes, for how long? _____

When was solid food introduced? _____

Food or feeding problems: _____

When did the child walk: _____ Talk: _____ Develop teeth: _____

Additional comments:

Vaccination History.

Please circle all applicable vaccinations.

MMR Age: _____ Chicken Pox Age: _____ Flu Age: _____
HepB Age: _____ Polio Age: _____ MCV Age: _____
DPT Age: _____ Hib Age: _____ HPV Age: _____
Others: _____

Please note any adverse reactions to vaccinations: _____

Additional comments:

System Overview.

Please circle all that apply.

Jaundice as baby	Diarrhea	Hyperactivity
Cradle cap	Constipation	Nightmares
Eczema/Psoriasis	Finicky eating	Bed wetting
Colic	Stomach aches	Tantrums
Chronic sniffles	Anemia	Epilepsy/Seizures
Allergies	Autism	Depression
Asthma	Growing pains	Early
puberty		
Very sweaty	Poor teeth	Disobedient
Diaper rash	Fears/phobias	Diabetes

Please describe your child's stools: _____

Additional comments:

Medication/Supplements.

List ALL medications (from the drugstore and/or prescription) your child is on now:

List all supplements/vitamins your child is on now:

Allergies.

Is your child allergic or hypersensitive to any:

Drugs? _____

Foods? _____

Animals? _____

Environmental Factors? _____

Diet.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Is there anything your child does NOT eat? _____

Additional comments:

Previous Medical History.

YES (Y) indicates the child gets the problem regularly; **NO (N)** indicates the child never had the problem; **PAST (P)** indicates the child had the problem in the past but not recently. Please circle the correct answers for your child.

Ear Infections: Y N P
Colds: Y N P
Strep Throat: Y N P

If has had, how many total: _____
If has had, how many total: _____
If has had, how many total: _____

How many times has the child taken antibiotics: _____

Hearing tests normal: Y N Not tested
Vision tests normal: Y N Not tested
Speech impediments: Y N P
Learning impediments: Y N P

Additional Comments:

V. Social History of Child.

Are both parents living in the home? Yes No

Names and ages of siblings, if any: _____

Pets: _____

Recent Travel: _____

Recent life changes: _____

Does your child attend school? Yes No If yes, what grade? _____

Any concerns about school? _____

Sports/activities: _____

Any particular household stressors your child has witnessed or gone through:

Is there anything else you would like to share with us?

Parent/Guardian Signature: _____ Date: _____