South Shore 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 Recreational Drugs
Preeclampsia Diabetes Emotional Stress
Vaginal Birth Coffee Nausea/Vomiting Traumatic Birth
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.

Are you currently up to date on vaccinations: Y or N

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	Emotional Concerns
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 If has had, how many total: ________________
Colds: Y N P If has had, how many total: ________________
Strep Throat: Y N P 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 you 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 important to you or your family to:
Avoid medications: Y or N
Include mindfulness and relaxation practices: Y or N
Use the gentlest medicine available: Y or N
Model healthy behavior for your child: Y or N
Would you like more information on holistic health options: Y or N

I have provided correct and complete information to the best of my knowledge.

____
____
Patient’s or Guardian’s signature Date

South Shore Community Acupuncture
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Asian body work and/or substances from the Oriental Materia Medica by a licensed acupuncturist at South Shore Community Acupuncture. I understand that acupuncturists practicing in the state of MA are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic’s practitioners. I consent to participating in yoga, relaxation and other mindfulness techniques and I am medically cleared to do so.

Signature: _____________________________Date:_____________________

Printed Name: ____