

CHILD HEALTH HISTORY

Date _____

Name _____ Parent _____

Address _____ State _____ Zip _____

Phone: _____ Work Phone: _____

Age _____ Date of Birth _____ # of Siblings _____ Birth Order _____

Family Practitioner _____ Referred by _____

Main Concern:

How long has this been going on?

Other Concerns:

Present Medications:

Other treatments going on at this time:

Has the child had acupuncture before? ___ Yes ___ No When/Where?

PLEASE INDICATE ANY PROBLEMS WITH THE FOLLOWING:

- | | | |
|---|---|--|
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> fevers | <input type="checkbox"/> flushed cheeks |
| <input type="checkbox"/> headaches | <input type="checkbox"/> convulsions | <input type="checkbox"/> thirst |
| <input type="checkbox"/> sinus infections | <input type="checkbox"/> pneumonia | <input type="checkbox"/> bladder/kidney infections |
| <input type="checkbox"/> nasal discharge | <input type="checkbox"/> ear infections | <input type="checkbox"/> thrush, vaginitis, severe diaper rash |
| <input type="checkbox"/> coughs | <input type="checkbox"/> eye problems | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> sore throats | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> blank or staring spells |

SLEEP:

- | | |
|--|--|
| <input type="checkbox"/> sleeps well | <input type="checkbox"/> sleeps with parents |
| <input type="checkbox"/> difficulty falling asleep | <input type="checkbox"/> disturbed dreams |
| <input type="checkbox"/> goes to bed awake | <input type="checkbox"/> night urination |
| <input type="checkbox"/> awakens regularly | |

MOODS:

- | | | |
|--|--|--|
| <input type="checkbox"/> emotionally stable | <input type="checkbox"/> moody | <input type="checkbox"/> fear, phobia, panic |
| <input type="checkbox"/> recent family divorce, moving, change of school, ect. | <input type="checkbox"/> severe emotional trauma | <input type="checkbox"/> hyperactive |
| <input type="checkbox"/> irritable | <input type="checkbox"/> withdrawn | <input type="checkbox"/> low attention span |
| | <input type="checkbox"/> pronounced changes | <input type="checkbox"/> abuse |

APPETITE:

- | | |
|---|--|
| <input type="checkbox"/> good appetite | <input type="checkbox"/> poor eater |
| <input type="checkbox"/> will only eat sweets | <input type="checkbox"/> specific preferences and dislikes |
| <input type="checkbox"/> very picky eater | |

Continue on the back

DIGESTION:

___ stomach aches ___ gas
 ___ belching ___ bloating

BOWEL MOVEMENTS:

___ irregular ___ constipation
 ___ loose ___ anal itching

SKIN:

___ itching ___ rashes ___ bumpy ___ cradle cap

BIRTH HISTORY:

Any complications? ___ Yes ___ No
 If yes, what where they?

Did the mother have any illnesses during gestation? ___ Yes ___ No
 If yes, what were they?

Birthweight: _____ Normal development? ___ Yes ___ No

FAMILY HEALTH HISTORY:

Major health problems of close family members:

Age and cause of death of close family members:

Do any family members have: ___ allergies ___ asthma ___ alcohol or drug abuse

Childhood Diseases:

Hospitalizations/surgeries:

Accidents? ___ Yes ___ No
 Broken Bones? ___ Yes ___ No
 Any scars? ___ Yes ___ No
 Allergies? ___ Yes ___ No

Any reactions to vaccinations: ___ Yes ___ No