Pediatric Health History Questionnaire

Information for your Acupuncturist.

Please complete this document as thoroughly as possible for your child. Some of the questions that follow may seem unrelated to his/her condition, however they may play a major role in treatment. All information is strictly confidential.

General Patient information

Date:______/______/______

Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: __________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Email: ____________________ Would you like to receive our email newsletter? ☐Yes☐No

Age:__________ Date of Birth: ____/____/____ Place of Birth: ____________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other

Name of Spouse/Partner/Other: ____________________

Guardian (if under 18): ____________________

Gender: ☐ Male ☐ Female Height: ____________________ Weight: ____________________

Social Security Number __________-______-__________ Drivers License Number: ____________________

Occupation: ____________________ Employer: ____________________

Employer Address: ____________________

City: ____________________ State: ____________________ Zip Code: __________

Goal from Acupuncture Services: ____________________

Is there anything limiting you from care: ☐ No ☐ Yes (explain) ____________________

Name of primary physicians/practitioner: ____________________

How did you hear about our office: ____________________

Other physicians/therapists seen for this: ____________________

Medications you are currently taking: 1) ____________________ 2) ____________________

3) ____________________ 4) ____________________ 5) ____________________ 6) ____________________

Prescribed by: ____________________

For the treatment of: ____________________

____

Results: ____________________

Supplements/Vitamins/Herbs: ____________________

____

____

ACUPUNCTURE WELLNESS
Experienced Care You Can Trust.
8351 Standonshire Way Ste 101 • Raleigh, NC 27615 • 919-846-2239

Pediatric Health History Questionnaire

Major complaints, in order of significance to you and your child:

Complaint	Severe	Moderate	Slight	Normal
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐
____________________	☐	☐	☐	☐

How do these conditions impair your child's daily activities? ____________________

____

____

Patient Medical History

How was your child's health so far? ____________________

____

Hospital Stays/Visits: ____________________

____

Recent Tests (indicate results & date below)

______ Blood

______ Hormone (salvia)

______ Other

Test Results & Date: ____________________

____

Acupuncture Wellness
Experienced Care You Can Trust.
8351 Standonshire Way Ste 101 • Raleigh, NC 27615 • 919-846-2239

Pediatric Health History Questionnaire

Prenatal History

During the pregnancy did any of the following occur:

_____emotional/physical stress or trauma
_____ hypertension
_____ pre-eclampsia
_____ nausea/vomiting
_____ infections
_____ bleeding
_____ tobacco use
_____ alcohol use
_____ recreational drug use
_____ anemia

Age of parents at conception: Mother __________ Father ___________

Natal History

Length of pregnancy:_____________________

At Birth: Weight ___________ Length ____________ Apgar score ___________

Type of Delivery: _____ Vaginal _____ Cesarean

Labor: ______ Spontaneous ________ Induced

Interventions: ________ Epidural ________ Episiotomy ________ Forceps

Duration of hospital stay (if applicable):____________

Neonatal History (0-2 Months)

Did you child experience any of the following complications after birth:

____ hypoxia
____ jaundice
____ feeding complications
____ meconium
____ rashes
____ colic
____ infection
____ fevers
____ voiding/eliminating difficulties
____ Other: _________________

Childhood Health History

Vaccinations

____ Diptheria tetanus pertussis (DTP)
____ Hemophilus B
____ Polio
____ Measles
____ Rubella
____ Mumps
____ Tetanus
____ Gardasil
____ Other

Acupuncture Wellness
Experienced Care You Can Trust.
8351 Standonshire Way Ste 101 • Raleigh, NC 27615 • 919-846-2239