origins

ACUPUNCTURE & WELLNESS

Patient's Name: ____

Date: _________ Age: _________ Date of Birth: ________________Gender: Female / Male
Parent/Guardian's Name:___________________________________ Insurance Plan: _________
Address:____
City: __________________________________ State: _____Zip:______________
Telephone (home): ____________________________ (Parent's work): _______________ Parent's email address:
____

How did you hear about this clinic?
____

Reason for referral or presenting problems:
____
____

MEDICATIONS IN PAST
____

MEDICATIONS CURRENTLY TAKING
____
Allergies to medicines: ______________________________

MEDICAL HISTORY

____ Chicken pox ____ Scarlet fever ____ Tonsillitis, approx no. of times: ____ Measles ____ Pneumonia ____ Ear infections, approx no. of times: ____ Mumps ____ Frequent colds ____ Strep throat, approx no. of times: ____ Rubella ____ Rheumatic fever ____
Other: ______________________________

Has your child ever had any of the following? WHEN?/WHERE?/RESULTS?

Electroencephalogram (EEG):
____
Psychological evaluations:
____
Hearing test:
____
Speech/language tests:
____
Injuries/surgeries/hospitalizations (please list):
____
Other
____

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IMMUNIZATIONS

____ MMR ____ DPT ____ Chicken pox Others:________________________________ ____ Measles
____ Diphtheria ____ Small pox Adverse reactions: Y / N
____ Mumps ____ Tetanus ____ H. influenza If so, what? ___________________________ ____ Rubella
____ Polio ____ The flu ____________________________________
____No immunizations given
Adverse reactions: Y/N

FAMILY HISTORY

____ Heart disease ____ Diabetes ____ Birth defects
____ Hypertension ____ Arthritis ____ Tuberculosis
____ Cancer ____ Allergies ____ Asthma
____ Mental illness ____ Osteoporosis ____ Others: ______________________________

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?
____
____ Mother's age at child's birth: ______

Mother's health during pregnancy:
____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Diabetes ____ Thyroid problems____ Medications, which ones?:____________________
Term: ____ Full ____ Premature ____ Late Weight at birth: ____________________
Length of labor: ____________________Complications:_________________________________
Did your child have any of the following problems shortly after birth?
____ Rashes ____ Birth injuries ____ Blue baby
____ Jaundice ____ Seizures ____ Cerebral palsy
____ Colic ____ Fever ____ Birth defects ____ Other:
____
Child's sleep patterns (1st year):
____
Food intolerances:
____
Breast fed: Y / N How long: ___________ Formula: Y / N Type (milk, soy):_____________ Age began solids: _________ Which foods: ____ Age began: Sitting _______ Crawling _______ Walking _______ Talking _________

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CURRENT SYMPTOMS

____ Hives ____ Burning urine ____ Bloody urine ____ Eczema
____ Cries easily ____ Bleeding gums ____ Heart murmur ____ Nervous
____ Nose bleeds ____ Vomiting spells ____ Sleep problems ____ Asthma
____ Acne ____ Anemia ____ Night sweats ____ High fevers
____ Jaundice ____ Sensitive to light ____ Chronic rash ____ Stomach aches ____ Diarrhea ____ Hearing loss ____ Easy bruising ____ Sore throats
____ Flat feet ____ No appetite ____ Body/breath odor ____ Constipation
____ Nightmares ____ Frequent colds ____ Bleeding tendency ____ Unusual fears ____ ____ ____ Wheezing ____ Joint pains ____ Excessive fatigue ____ Cough
____ Dizzy spells ____ Hair loss ____ Frequent urination ____ Allergies

DIET

Please describe your child's typical daily diet:
Breakfast:
____Lunch:
____Dinner:
____Snacks:
____To drink:
____