Child History Form

Name_____ Parent_____

Age_____ Date of Birth_____#of Siblings_____ Birth Order_____

Phone Number_____

Adress_____

Main Concern_____
How long has this been?_____

Other Concerns?_____

Present Medications_____

Other treatments at this time_____

Has child has acupuncture before?_____ When/Where_____

Please indicate any problems with the following:

Frequent colds Ear infections Eye(s) problems Convulsions Fevers

Headaches Sinus Infections Nosebleeds Thirst

Nasal Discharge Flushed Cheeks Coughs Muscle Cramps

Pneumonia Sore throats Bladder/Kidney Infections

Blank or Staring Spells Thrush, Vaginitis, Severe Diaper Rash

Sleep

Sleeps Well Difficulty Falling Asleep Goes to Bed Late

Disturbed Dreams Night Urination Awakens Regularly Sleeps with Parents

Moods

Emotionally Stable Moody Fear, Phobia, Panic

Hyperactive Withdrawn Low Attention Span

Irritable Abuse Severe Emotional Trauma

Pronounced Mood Changes Recent Family Divorce/Moving/Change of School

Appetite

Good Appetite Poor Eater Very Picky Eater

Will Only Eat Sweets Specific Preferences and Dislikes

Digestion

Stomach Aches Belching Gas Bloating

Bowel Movements

Irregular Loose Constipation Anal Itching

Skin

Itching Bumpy Rashes Cradle Cap

Birth History

Any Complications?

_____

Mother's illness during gestation:_____

Birth Weight_____

Normal Development?_____

Family Health History

Major health problems of close family member:_____

Age and cause of death of close family members:_____

Do any family members have: Allergies, Asthma, Alcohol/Drug Abuse_____

Childhood disease:_____

Hospitalization/Surgeries_____

Accidents:_____

Broken Bones:_____

Any scars?_____

Allergies?_____

Any reaction to vaccines?_____