TO THE POINT ACUPUNCTURE

PEDIATRIC HEALTH HISTORY QUESTIONAIRE

Please take the time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

Child's Full Name:____ Date:________________________
Address:
____

Guardian's Full Name and Relationship:____
Home phone #:_____________________ Work #:_____________________ Cell #:___________________________
Child's Height:__________ Child's Weight_________ Date of Birth:__________________ Age:_____________
Health Insurance Company:____
Child's Pediatrician:____
HOW DID YOU HEAR ABOUT THIS OFFICE? ____

MAIN PROBLEM:
What has brought you to *To The Point Acupuncture*?
Please rank in order of importance to your child and be as specific as you can:

1. ____
2. ____
3. ____

Current Medications and their dosages (this includes supplements, herbs, and home remedies):
____
____
____

Known Allergies (please include reactions to Medicines or Vaccinations:________________________________
____

PREGNANCY:
List any medications/drugs taken during pregnancy (include over the counter medications):____________________
____
Any Alcohol? Y N How much?________________ Any Tobacco? Y N How much? _________________
High Blood Pressure? Y N Illnesses or infections during pregnancy? Y N ___________________________
Please indicate any medical problems during pregnancy ☐ None ☐ Specify: ______________________________
____

LABOR AND DELIVERY:
Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:____
Delivery by: ☐ Vaginal birth ☐ Caesarean If caesarean, why? ____
Breech or unusual presentation? ☐ No ☐ Yes ____
Pain medication used? ☐ No ☐ Yes Pitocin used? ☐ No ☐ Yes Forceps used? ☐ No ☐Yes
Delay in respiration or cry? ☐ No ☐ Yes Was oxygen administration necessary? ☐ No ☐ Yes
Apgar score, if known:_______ Type of anesthesia employed for mother: ______________________________________
Birth weight (lbs.):____________ Birth length (in.): _______________ If premature, how early? ___________________

Please indicate any medical problems during the baby's birth. ☐ None

____

NEWBORN:
Jaundice ☐ No ☐ Yes Infection ☐ No ☐ Yes Seizures ☐ No ☐ Yes Anemia ☐ No ☐ Yes
Home from hospital in ______ days.
Please indicate any problems during the newborn period. ☐ None

____

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NUTRITION AND FEEDING:
Is your child breastfed? ☐ No ☐ Yes If so, how long? ____
Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, please specify:______________

____

INFECTIOUS DISEASE:
Has your child had: ☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis
☐ Other: ____

IMMUNIZATIONS:
Is your child following the childhood vaccination schedule as recommended by his/her pediatrician? ☐ No ☐ Yes
Any complications from vaccinations? ☐ No ☐ Yes

____

EXPOSURES:
Any concerns about lead exposure? (old home/plumbing/peeling paint) ☐ No ☐ Yes
Do any household members smoke? ☐ No ☐Yes

ILLNESSES:
Hospitalizations:
Age:____________ Reason:____
Age:____________ Reason:____
Age:____________ Reason:____

Any history of head injury? ☐ No ☐ Yes ____
Has your child ever been unconscious? ☐ No ☐ Yes ____________________________________

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

____

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____

ANY ADDITIONAL INFORMATION:____

____

____

____ ______________________________

Signed and Dated Relationship to Child