To The Point Acupuncture, LLC
1215 Jones Franklin Road, Suite 202
Raleigh, NC 27606
(919) 621-3363

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? _____
HAS YOUR CHILD EVER RECEIVED ACUPUNCTURE BEFORE?_____

MAIN PROBLEM:
What has brought you to *To The Point Acupuncture,LLC*?
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? _____

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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

_____

_____

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.

_____

_____

_____

ANY ADDITIONAL INFORMATION:_____

_____

_____

_____ _____
Signed and Dated Relationship to Child