healthy happy whole

Integrative Medicine & Wellness Center

Age 0-13 years

# Pediatric Patient Registration

This is a CONFIDENTIAL questionnaire. Your current and past health history will be evaluated in order to provide a customized treatment plan that meets your medical and wellness goals.

Child's Full Name _____ Name Preference _____

Date of Birth _____ Age _____ Gender: ☐ Female ☐ Male Place of Birth _____

Adopted: ☐ Y ☐ N If yes, at what age _____ What Country _____

Number of Siblings _____ Ages of Siblings _____ Birth Order: ☐ Oldest ☐ Middle ☐ Youngest

Child primarily lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

Parent(s)/Guardian(s) are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnership

Primary Address _____ City _____

State _____ Zip _____ Email _____

☐ Home (___) _____ ☐ Work (___) _____ ☐ Cell (___) _____

Please mark above which number(s) you will prefer to receive messages. Best time to call _____ AM _____ PM

Secondary Address _____ City _____

State _____ Zip _____ Email _____

☐ Home (___) _____ ☐ Work (___) _____ ☐ Cell (___) _____

Please mark above which number(s) you will prefer to receive messages. Best time to call _____ AM _____ PM

Child's School _____ Grade _____ Teacher _____

Emergency Contact _____ Relationship _____

Phone 1 (___) _____ Phone 2 (___) _____

Who may we thank for referring you? _____

Healthy Happy Whole will never sell or transfer your information to third parties.
May we contact you for follow up care and to share important clinic updates: ☐ Yes ☐ No

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Height ____ ' ____ " Weight _____ Known Allergies _____

Date of last physical exam _____ With whom _____

Reported findings _____

Doctor's Name _____ Phone (___) _____

Address _____ City _____ State _____ Zip _____

Email _____ @ _____ ☐ You have my permission to contact this doctor

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Purpose of this Appointment _____

Have you sought other treatment / consulted another medical professional for this condition? ☐ Yes ☐ No

If yes, what forms of treatment have you sought? _____ When _____

Were the treatments helpful? ☐ Yes ☐ No Explain _____

Please list any other Health Concerns _____

## CONCEPTION/PREGNANCY/BIRTH HISTORY

| HEALTH AT CONCEPTION | HEALTH THROUGHOUT PREGNANCY | AGE AT TIME OF BIRTH | # OF PREVIOUS PREGNANCIES |
|---|---|---|---|
| Mother | Poor Fair Good Excellent | | |
| Father | Poor Fair Good Excellent | | |

Did the mother experience any food cravings/aversions during pregnancy? ☐ Yes ☐ No

If yes, please list:_____

Did the mother receive medical care during pregnancy? ☐ Yes ☐ No ☐ Unknown

Did the mother experience any of the following during pregnancy? ☐ Bleeding ☐ Nausea ☐ Vomiting ☐ Diabetes

☐ High Blood Pressure ☐ Thryroid problems ☐ Physical/Emotional trauma ☐ Other _____

Where any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Chorionic villi sampling ☐ Triple screen ☐ Amniocentesis ☐ Maternal serum screening

Did the mother use any of the following during pregnancy? ☐ Tobacco ☐ Diet Soda ☐ Alcohol ☐ Recreational Drugs

☐ Prescription and/or Over the Counter Medications_____

☐ Vitamins and/or Supplements_____

Length of pregnancy (in weeks)_____ Complications during pregnancy_____

Number of hours in Labor_____ Complications during labor/delivery_____

Type of delivery: ☐ Vaginal ☐ Caesarian Location of birth: ☐ Hospital ☐ Home Birth ☐ Birthing Center

Did the mother receive the following: ☐ Oxytocin/Pitocin ☐ Epidural ☐ Forceps Vacuum Device ☐ Episiotomy

Please describe Mother's emotional state after birth _____

Please describe the Partner's emotional state after birth_____

## GROWTH & DEVELOPMENT

At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____ Begin Teething_____

Where there any difficulties associated with teething? _____

Has your child experienced any pubertal changes? _____

## IMMUNIZATIONS

| IMMUNIZATION | YES | AGE(S) | YEAR(S) | REACTION (IF ANY) |
|---|---|---|---|---|
| Hepatitis B | ☐ | | | |
| Rotavirus | ☐ | | | |
| DPT (Diphtheria, Pertussis, Tetanus) | ☐ | | | |
| Haemophillius Influenza Type B | ☐ | | | |
| Penumococcal | ☐ | | | |
| Inactivated Poliovirus | ☐ | | | |
| Influenza | ☐ | | | |
| H1N1 | ☐ | | | |
| MMR (Measles, Mumps, Rubella) | ☐ | | | |
| Varicella (Chickenpox) | ☐ | | | |
| Hepatitis A | ☐ | | | |
| Meningococcal | ☐ | | | |
| Human Papillomavirus | ☐ | | | |
| Other: | ☐ | | | |

## HEALTH HISTORY

☐ Rubella ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Strep throat ☐ Chickenpox

☐ Diaper Rash ☐ Cradle cap ☐ Polio ☐ Whooping cough ☐ Rheumatic fever ☐ Colic

☐ High fevers How many_____ ☐ Bedwetting How often? _____

Surgeries, Hopsitalizations, Serious Illnesses (List year in brackets) _____

Injuries, Accidents, Major Dental Work (List year in brackets) _____

SYMPTOM SURVEY

Please mark the symptoms the patient: + Frequently experiences
✓ Sometimes experiences

___ Low appetite
___ Excessive appetite
___ Loose stool or diarrhea
___ Constant worry
___ Sadness
___ Difficulty concentrating

___ Digestive problems, indigestion
___ Vomiting / Nausea
___ Ulcers
___ Feeling retention of food in the stomach
___ Fatigue after eating
___ Obsession in activities or relationships

___ Heartburn, reflux
___ Belching, burping
___ Abdominal bloating
___ Irritability eased with food
___ Easily bruised
___ Mind racing

___ Insomnia
___ Heart palpitations
___ Mentally restless
___ Nightmares
___ Flushed Cheeks
___ Laughing for no reason

___ Chest pain
___ Abdominal pain
___ Pain or coldness in the genital area
___ Afternoon fevers
___ Hot hands and feet
___ Cold hands and feet

___ Headache
___ Migraine
___ Rib-side pain/discomfort
___ Excessive thirst
___ Enlarged lymph glands
___ Bleeding gums

___ Cough
___ Shortness of breath
___ Decreased sense of smell
___ Nasal problems
___ Skin problems
___ Unexplained weight loss

___ Bronchitis
___ Coughing blood
___ Recent use of antibiotics
___ Phlegm: ☐ Nose ☐ Chest/cough
Easy to expectorate: ☐ Yes ☐ No
Color: ☐ Clear ☐ White ☐ Yellow ☐ Brown ☐ Green

___ Sinus Congestion
___ Allergies
___ Sore throat
___ Ear aches or infection
___ Dizziness

___ Muscle spasms/twitching
___ Muscle weakness
___ Numbness/tingling
___ Eye twitching
___ Eye problems/floaters

___ Easily angered or agitated
___ Intestinal gas
___ Constipation
___ Difficulty making plans or decisions
___

___ Difficulty digesting oily foods
___ Jaundice (yellowish skin or eyes)
___ Gall stones
___ Light colored stool
___ Hemorrhoids

___ Low back pain
___ Sore or painful knees
___ Ear ringing
___ Hearing impairment
___ Hair loss
___ Delayed growth/development

___ Asthma / Wheezing
___ Intolerance to weather changes
___ Often cold, prefers warmth
___ Tendency to catch colds easily
___ Fatigue

___ Urinary problems
___ Bedwetting
___ Blood in stool
___ Black tarry stool
___ Edema

___ Acne or Boils
___ Eczema
___ Psoriasis
___ Ringworm or Fungus

___ Rashes
___ Itching
___ Dandruff
___ Dry skin

___ Hives
___ Mouth sores
___ Athlete's foot
___ Soft, brittle nails

Sweating: ☐ Easily ☐ Rarely ☐ Hot Flashes ☐ Night Sweats
Temperature: ☐ Cold ☐ Warm ☐ Over-heated
Infectious Dz: ☐ HIV ☐ Herpes ☐ Hepatitis B

DIETARY LIFESTYLE AT INFANCY

How is/was your infant fed? ☐ Breast fed ☐ Formula: Milk / Soy / Other_____

For how long?_____ Any reactions to the breast milk or formula? ☐ Yes ☐ No

If yes, please explain_____

What foods were introduced **before 6 months**? Please list the approximate age (by month) and any reactions.

| FOOD | AGE | ANY REACTIONS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

DIETARY LIFESTYLE

Food cravings _____ ☐ Salty ☐ Sweet ☐ Sour ☐ Bitter ☐ Fats/Greasy

Known food sensitivities _____

Mark any dietary choices that apply: ☐ Vegetarian ☐ Vegan ☐ Kosher ☐ Raw ☐ Other _____

Please list any restrictions to the patients diet _____

Number of 12 oz glasses of WATER per day? _____ Does the patient drink soda? ☐ Yes ☐ No

Number of 12oz glasses of SODA per week? _____ ☐ Diet ☐ Regular Brand(s) _____

Does the patient experience gas, burping, abdominal bloating, acid reflux after eating any foods? ☐ Yes ☐ No

Please list these foods/beverages _____

Is your child currently Dieting? ☐ Yes ☐ No If yes, please describe _____

TYPICAL MEALS

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Number of meals per day _____ Does the patient eat at the same times each day? ☐ Yes ☐ No

Number of snacks per day _____ Does the patient eat at restaurants? ☐ Yes ☐ No Times per week? _____

OTHER

Does your child sleep well? ☐ Yes ☐ No Sleep _____pm/am Wake _____pm/am Average Hours/night _____

If no, please describe _____

Bowel Frequency _____ # Times/day Difficulty ☐ Yes ☐ No _____

Urinary Frequency _____# Times/day Difficulty ☐ Yes ☐ No Does your child wake to urinate? ____ # Times/Night

DIAGNOSTIC TESTING

☐ Blood work Date _____ Results _____ ☐ MRI Date _____ Results _____

☐ CT scan Date _____ Results _____ ☐ Urinalysis Date _____ Results _____

☐ EKG Date _____ Results _____ ☐ X-Ray Date _____ Results _____

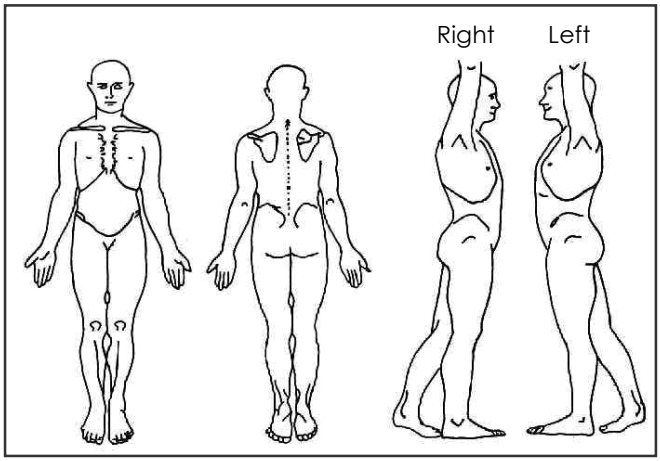
FAMILY MEDICAL HISTORY

| DISORDER | MOTHER | FATHER | BROTHER | SISTER | MATERNAL GRANDMOTHER | MATERNAL GRANDFATHER | PATERNAL GRANDMOTHER | PATERNAL GRANDFATHER |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | | | | | | |
| Heart Disease | | | | | | | | |
| Stroke | | | | | | | | |
| Diabetes | | | | | | | | |
| Cancer | | | | | | | | |
| Seizures | | | | | | | | |
| Rhematic Fever | | | | | | | | |
| Neurologic Disorder | | | | | | | | |
| Thyroid Disorder | | | | | | | | |
| Anemia | | | | | | | | |
| Arthritis | | | | | | | | |
| Alzheimers | | | | | | | | |
| Hepatitis | | | | | | | | |
| Alcoholism | | | | | | | | |
| HIV/AIDS | | | | | | | | |
| Emotional Disorder | | | | | | | | |
| Eating Disorder | | | | | | | | |
| Infertility | | | | | | | | |
| Birth Defects | | | | | | | | |
| Learning Disability | | | | | | | | |

## PAIN ASSESSMENT

Does the patient have chronic, on-going pain? ☐ Yes ☐ No

Please draw the location of the pain below. Use heavier shading in areas of more intense pain.




Initial onset (Date/Year) _____

Due to: ☐ Injury/trauma ☐ Auto accident ☐ Repetitive stress
☐ Other _____

Characteristics: ☐ Dull/Achy ☐ Sharp/Stabbing ☐ Tingling
☐ Pain moves ☐ Localized ☐ Comes & goes ☐ Constant

What activities cause/make the pain worse? _____

What makes it better? _____

## MEDICATIONS

Please mark and list ALL of the medications your child is currently taking.

| | | |
|---|---|---|
| ☐ Advil/Ibuprofen/Tylenol | ☐ Cold medication | ☐ Herbal formulas/tinctures |
| ☐ Allergy medication | ☐ Aspirin | ☐ Sleeping pills/tranquilizers |
| ☐ Antacids | ☐ Blood thinner (Coumadin/Warfarin) | ☐ Laxatives |
| ☐ Antibiotics | ☐ DHEA/Melatonin | ☐ Steroids |
| ☐ Antidepressants | ☐ Diet pills | ☐ Supplements |

Approximately how many courses of antibiotics has the patient taken since birth? _____

List the names of ALL medications/supplements you are currently taking (continue on the back if necessary):

Medicine/Dosage Reason How Long Prescribed by Last appointment

_____

_____

_____

_____

## PATIENT PROFILE

Has your child received acupuncture or massage before? ☐ Yes ☐ No If so, when? _____

With whom? _____

☐ DOM/Licensed Acupuncturist ☐ Chiropractor/Doctor ☐ Other _____

Please list any other health care professionals that is currently treating your child (Therapist, Chiropractor, Specialist, other)

Name_____ Phone (____) _____ Specialty_____

Name_____ Phone (____) _____ Specialty_____

Name_____ Phone (____) _____ Specialty_____

## MEDICAL REMINDERS

The patient is currently taking: ☐ Anti-seizure Medication ☐ Blood Thinner (Coumadin/Warfarin) ☐ Antibiotics

Current Allergies: _____

The above information is accurate and true to the best of my knowledge. I understand that an acupuncture appointment could include a variety of therapeutic modalities such as cupping, guasha, moxabustion, Tuina (medical massage), dietary and nutritional counseling, herbal formulas/tinctures/tea, infra-red heat therapy, moist heat therapy, Qi Gong, or other breathing exercises and stretching. I am aware that acupuncture involves the placement of sterilized, individual use, disposable needles through the skin, which may produce a mild, but temporary discomfort at the site of treatment. The removal of an acupuncture needle may occasionally cause slight bleeding, and rarely causes bruising. Extremely rare risk includes nerve damage or organ puncture. Other possible risks from acupuncture include dizziness and fainting or light-headedness. I will report to my Licensed Acupuncturist if my child feels any of these symptoms during or after an acupuncture treatment.

I understand that I am responsible for full payment for any and all scheduled appointments, including missed and cancelled appointments without 24 hours notice. I have read and agree to all terms of the cancellation policy.

By signing below, I show that I have read and understand the possible risks and complications involved in treatment. I take responsibility for alerting my practitioner to any physical or emotional changes that occur with the health of my child. If I have any questions or concerns before, during or after any treatment, I will bring them to the attention of the practitioner.

Parent/Guardian Signature _____ Printed Name _____ Date _____

Practitioner Signature _____ Printed Name _____ Date _____