Acupuncture & Natural Health Solutions
Pediatric Patient Questionnaire - Page 1

Patient's Name: _____ DOB: _____

Address: _____ SS#:_____

City: _____ State: _____ Zip Code: _____ Sex: M / F

Contact Email: _____ Daytime Phone: _____

Evening Phone: _____ Work Phone: _____

Emergency Contact: _____

Mother's Name & Occupation: _____

Father's Name & Occupation: _____

Parents are (circle): Married Separated Divorce Other: _____

Insurance Company: _____ Insured Name: _____

Relationship to Patient: _____ Employer: _____

Insurance ID: _____ Group #: _____ Copay: _____

Insured's Date of Birth: _____ Insured's SS#: _____

Referred by: _____

I give Toni Eatros, AP permission to email me appointment & notifications & announcements Y N

Reason for Office Visit: _____

_____

Has your child been seen by any other doctor(s) for this complaint (circle)? Yes No Past

Please describe past care for this complaint: _____

_____

_____

Pediatrician's Name & Phone: _____

Last time child had blood work done & what labs (bring copies if possible): _____

_____

Known allergies to food, drugs, environment, animals, etc: _____

List all surgeries & hospitalizations, include dates:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

List all medications (from drugstore or prescription) child is on now and dosages:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

List all supplements child is now taking, and dosages:

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Previous Medical History

Please circle the correct one for your child

Y = Yes indicates the child gets the problem ***regularly***

N = No indicates the child ***never*** has the problem

P = Past indicates the child had the problem in the ***past, but not recently***

Ear Infections: Y N P If has had, how frequent per year? _____

Colds: Y N P If has had, how frequent per year? _____

Strep Throat: Y N P If has had, how frequent per year? _____

How many total times has your child taken antibiotics? _____

Has your child ever had any of the following?

Chicken Pox: Y N Age: _____ Rubella: Y N Age: _____ Mumps: Y N Age: ____

Whooping Cough: Y N Age: _____ Rubeola: Y N Age: _____

List medications that the child has taken regularly in the past and how often:

1.) _____ 3.) _____

2.) _____ 4.) _____

Hearing test normal? Y N Not Tested _____

Vision test normal? Y N Not Tested _____

Speech Impediments? Y N Not Tested _____

Learning Impediments? Y N Not Tested _____

Vaccination History

Yes = has had **No** = has not had **Some** = did not finish all shots in the series

MMR: Yes No Some **DPT:** Yes No Some **Hep B:** Yes No Some

Hib: Yes No Some **Chicken Pox:** Yes No Some **Polio:** Yes No Some

Others: _____

Any reactions to vaccinations? If so, please explain: _____

_____

_____

Family HIstory

Allergies: Y N P **Obesity:** Y N P **Cancer:** Y N P

Tuberculosis: Y N P **Mental Illness:** Y N P **Heart Disease:** Y N P

Other disease in your family: _____

If you answered yes to any of the above, please write relationship of family member to child and severity of the disease: _____

_____

Mother's Pregnancy History

Age at conception: _____ Length of Labor: _____ Vaginal Birth? Y N

Traumatic Birth? Y N If yes, please explain: _____

_____

_____

Medications used during pregnancy: _____

How many ultrasounds during pregnancy? _____

Birth interventions (circle one): Forceps Vacuum Extraction C-Section Induction None

During pregnancy did any of the following occur?

Smoking? Y N Diabetes? Y N Nausea/Vomiting? Y N

Recreational Drugs? Y N Emotional Stress? Y N Alcohol? Y N

Pre-eclampsia? Y N Coffee? Y N

Dietary restrictions during pregnancy? Y N If yes, explain: _____

_____

Health History of Child

Gestational age at birth (weeks at birth): _____ Apgar scores: _____

Birth weight: _____ Birth length: _____

Complications after delivery: Y N If yes, please explain: _____

_____

Location of Birth (circle one): Hospital Birthing Center Home Other: _____

Child was breastfed? Y N For how long? _____ When put on formula? _____

What formula was used? _____ When was solid food introduced? _____

First foods eaten: _____

When was whole milk introduced? _____

Any food cravings? _____

Age child walked? _____ Talked? _____ Developed teeth? _____

Jaundice as a baby: Y N Colic: Y N Cradle Cap: Y N

Anemia: Y N Eczema or Psoriasis: Y N Stomach Aches: Y N

Diarrhea: Y N Constipation: Y N Asthma: Y N

Warts: Y N Finicky eating: Y N Nightmares: Y N

Poor Teeth: Y N Bed Wetting: Y N Chronic sniffles: Y N

Excessive Tantrums: Y N Bad foot odor: Y N Defiant: Y N

Very sweaty: Y N Fears/Phobias: Y N Hyperactivity: Y N

Diaper Rash: Y N Growing Pains: Y N

Early Puberty: Y N If yes, what age? _____

Any particular household stressor child has witnessed or experienced?

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Environmental Exposure

Has the child ever lived near a refinery, polluted area or in a home with lead paint? If so, what sort of pollution were they exposed to? _____

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health? _____

_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

What year was your home built? _____ Vinyl blinds? Y N Year installed? _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Other Questions

List any questions you would like the acupuncture physician to address during this appointment:

_____

_____

Primary Care Physician

Name/Office _____

Address _____

Phone _____

Specialists

(EENT, Gastroenterologists, Psychiatrists, Counselors, Chiropractic, Massage, etc)

Specialty/ Seen for _____

Name/Office _____

Address _____

Phone _____

Specialty/ Seen for _____

Name/Office _____

Address _____

Phone _____

Authorization for Care of a Minor

I hereby authorize Toni Eatros, AP to administer care to my Son/Daughter as they deem necessary. I clearly understand that I have the right to refuse care and that I am personally responsible for payment of all costs associated with the treatment of care:

Parent/Guardian: _____ Date: _____

Witnessed: _____ Date: _____