CHINESE MEDICINE & HERBAL REMEDIES
SUNNY JAYNES
EST. 2009 ACUPUNCTURE PORTLAND, OR

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Pediatric Health History Form

Patient's Name: _____ Today's Date: _____
Your name: _____ Relationship to Child: _____
Patient's Date of Birth: _____/_____/_____ Age: _____Gender: _____
Street Address: _____City: _____
State: _____ ZIP code: _____ Contact Tel. #: _____(home cell work other)
Alternate #: _____(home cell work other)
Alternate/Emergency Contact: _____Relationship to child: _____Telephone: _____
Where did you hear about us?
_____
Has any other family member been a patient at this clinic?
_____
Successful health care and preventative medicine are only possible when the practitioner has an understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible, and indicate areas of confusion with a question mark. Thank you.
When and where did the child last receive health care?
_____
For what reason?
_____
_____

What are your main concerns about the child's health? Please list in order of importance:

Condition
1. _____ Past treatment_____
How does this condition affect the child?
_____
2. _____ Past treatment: _____
How does this condition affect the child?
_____
3. _____ Past treatment: _____
How does this condition affect the child?
_____

Please place a check next to any medications the child is taking now or has taken in the past:

NOW	PAST		NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Ibuprofen	____	____	Other: _____
____	____	Decongestants	____	____	Tylenol	____	____	Other: _____
____	____	Anti-histamine	____	____	Antibiotics	____	____	Other: _____

If applicable, please list any foods, drugs, or substances the child is hypersensitive or allergic to (please include reaction):
_____
_____
_____

Date of child's last physical exam: _____Date of last dental exam, if applicable: _____
Dental work done: _____
Has your child ever had any of the following? (please include when, why and results)
Hearing test: _____
Speech/language tests: _____
Injuries/surgeries/hospitalizations (please list):

_____
_____

Please circle any of the following conditions that the child has experienced:

Chicken Pox	Measles	Mumps
Rubella	Scarlet Fever	Pneumonia
Frequent Colds	Rheumatic Fever	Tonsillitis
Ear Infections	Strep Throat	Asthma
Allergies	Croup	Colic

Pertussis (whooping cough)

Please circle any immunizations the child has had:

MMR	Measles	Mumps
DPT	Diptheria	Tetanus
Polio	Hib. flu	Chicken Pox
Flu virus	Small Pox	Hep. B.
Hep. A	Pertussis	Other:_____

Adverse Reactions? Y/N If so, what? _____

Does the child have a family history of any of the following? (please circle, if known)

Heart Disease	Mental Illness	Allergies	Hypertension
Diabetes	Osteoporosis	Cancer	Birth defects
Tuberculosis	Asthma	Arthritis	Other: _____

Prenatal History (if known):
Mother's age at child's birth: _____ Prenatal care? Y / N
Difficulty conceiving? Y / N Infertility treatments used? Y / N

Mother's health during pregnancy (if known):

Bleeding	Illnesses	Nausea	Physical or emotional trauma
Diabetes	Thyroid issues	Medications	Drug or alcohol dependency

Hypertension other: _____

Birth History (if known):
Weeks gestation at birth: _____ Vaginal or C-section (please circle)
Weight at birth: _____ Length of labor: _____
Complications: _____
_____
Were forceps or vacuum extraction used? _____

Did the child have any of the following shortly after birth?

Rashes	Birth injuries	Cerebral Palsy	Colic
Jaundice	Seizures	Birth Defects	Fever

Dietary History:
Breast fed? Y / N How long? _____ Formula fed? Y / N How long? _____
What type?_____ Food intolerances? _____
Age began solids: _____Which foods? _____
Does the child have any dietary restrictions? (religious, vegetarian, allergies, etc.)

_____
Describe Child's Typical Daily Diet:
Breakfast:_____
Lunch:_____
Dinner: _____
Snacks: _____
Drinks: _____
Number of bottles given per day (include bottle size): _____
Nursing frequency: _____

Health and Development:
How was your child's health in the first year? Poor Fair Good Excellent Unknown
At what age did your child first: Sit Up: _____Crawl: _____ Walk: _____Talk: _____
Describe your child's sleep pattern:

_____
_____
Social/Environment:
Is your child in: School (grade_____) Daycare Homecare Other:_____
Who is/are the child's primary caregiver(s)? _____
What are your child's favorite activities? _____
Please describe the child's temperament: _____
What are the child's strengths and challenges?_____

_____
Does your child exercise regularly? Y / N
How much and how often?_____
Does anyone in the house smoke? Y / N
How much television does your child watch? _____hrs per (*please circle*: day / week)
Are there any animals in the house? Y / N Type:_____
How would you describe the emotional climate of the child's home?

_____
_____

DECLARATION AND CONSENT TO TREATMENT OF A CHILD
Child's name: _____
Date: _____
I, _____, hereby give my consent for the treatment of my child or ward by Sunny Jaynes. I take responsibility for all fees incurred.
Signature: _____
Date: _____
Relationship to child: _____