**Rachel Kriger, M.Ac., L.Ac.**    **Points Of Return Acupuncture**  **215-495-3229**

## Pediatric Health History Questionnaire

This is a confidential questionnaire to help us determine the best treatment plan for your child. Please take the time be as thorough as possible. If you have any questions, please feel free to ask. Thank you.

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| --- | --- |
| Patient Name:       | Date Date of Birth:       Age:       |
| Address:       | Height:       Weight:       Sex: ☐M ☐F |
|        | Place of birth       |
| Parent Name       | Has patient ever received acupuncture? ☐Y ☐N |
| Phone: (H)       (C)       | Referred to this office by:       |
| Marital Status:       email:       | Physician:       |
| In Emergency Notify:       | Relationship:      Phone:       |

Where did you learn of Rachel Kriger & Points of Return Acupuncture?

Main health concern:

When did the problem begin (be specific):

To what extent does the problem interfere with daily activity (play, appetite, sleep, etc.)?

Have you been given a diagnosis for the problem? If so, what?

Secondary health concerns:

**Past Medical History**

☐Croup ☐Mumps ☐ Chicken Pox ☐ Measles ☐Rubella ☐Measles ☐Roseola ☐Seizures

☐ Rheumatic Fever ☐Hand Foot Mouth ☐Scarlet Fever ☐HIV/AIDS ☐Diabetes ☐RSV

How many times has patient had the following: Ear Infection:      Strep Throat:

Is patient suffering from any chronic illness?

**Has your child had any of the following?**

Psychological evaluations      Hearing tests      Speech/language tests

Surgeries (type & date):

Significant Traumas (emotional or physical):

Allergies (drugs, chemicals, foods, etc.)

**Immunizations**

Is the patient following the recommended immunization schedule?

Has patient had any adverse reactions to immunizations?

**Family Medical History**

☐ My child was adopted and my information is limited

☐Cancer ☐Asthma ☐Heart Disease ☐Diabetes ☐Stroke

☐Allergies ☐Hypertension ☐Sezuires Other

**Conception, Pregnancy, and Birth**

Method of conception (natural, IVF, etc.):       Mother’s age at birth:

Length of Pregnancy:       Complications during pregnancy?

**Were any of the following experienced during pregnancy?**

☐Bleeding ☐Physical or emotional trauma ☐High blood pressure ☐nausea/vomiting

☐depression/anxiety ☐thyroid problems ☐illnesses ☐gestational diabetes

Consuption of: ☐Cigarettes ☐Alcohol ☐Drugs

Length of Labor/Delivery:       Complications during labor/delivery?

**Delivery methods, check all that apply:**

☐Vaginal ☐C-section ☐Anesthesia ☐Forceps ☐Induction ☐Vacuum

Weight at birth:       Length at birth:

**Did the patient have any of the following problems shortly after birth?**

☐Rashes ☐Birth injuries ☐Blue baby ☐Jaundice ☐Seizures ☐Cerebral palsy

☐Colic ☐Fever ☐Birth defects ☐Other

**The First Year**

Was the patient breast fed?      If so, for how long?

Age began: solids:     Sitting:     Crawling:     Walking:      Talking:

Sleeping patterns in first year:

**Medications and Supplements**

**Please include the Name, dosage or how often, reason for taking, and length of time taken.**

Has the patient had any courses of antibiotics recently? ☐yes ☐no

Approx. how many courses of antibiotics has the patient had since birth?

**Habits**

Is patient on a restricted diet? If so what kind and why?

**Please indicate usage per day or per week:**

Water      per       Soda ☐regular☐diet      per

Juice      per       Milk (include type)      per

**What are typical meals like?**

Breakfast

Lunch

Dinner

Snacks

How much screen time does your child have each day/week?

How many hours does the patient sleep at night?       What time is bed time?

Does the patient sleep well and wake rested?      Does the patient nap?       How long?

**Pain**

Please describe **in detail, the location** of any areas of pain or distress

How long has the patient had this pain?

What was the onset?

What makes the pain better?

What makes the pain worse?

What treatments have you tried?

**Social Life, Behavioral/Emotional**

How would you describe your child’s temperament?

What is the birth order of your child?

Does your child attend school?      What grade?

Do you have any concerns about your child’s social interactions?

Have there been any recent life changes?

|  |
| --- |
| **Does the patient suffer from any of the following?**For each symptom patient has currently or recently, rate the severity on a scale of 1-5 with 5 being the worst.  |
| **LU/LI**  dry cough cough with sputum runny nose sinus infection/congestion red, dry or itchy nose dry mouth, throat eczema/psoriasis snoring grief/sadness shortness of breath allergies/asthma easily catches colds**LV/GB** irritability/anger headaches/migraines visual problems red, dry or itchy eyes dizziness teeth clenching muscle cramps/twitching brittle nails hernia | **ST/SP** colic fatigue edema weak muscles easy bruising bad breath change in appetite crave sweets anemia gas/burping nausea/vomiting picky eating  constipation diarrhea abdominal pain indigestion/reflux over thinking failure to thrive obsessive tendencies poor motor development | **UB/KD** back pain urination problems joint pain early puberty late puberty knee pain developmental delays poor memory hair loss hearing problems craving salty foods fearful night sweats**HT/SI** chest pain laughing for no reason nightmares palpitations insomnia easily startled restless/ agitation heart murmur |

**Phew! I know that was a lot, thank you for your time and effort. Is there anything else you would like for me to know?**

**For Young Women**

Age of 1st period      #of pregnancies      #children (live births)

Are you pregnant? ☐yes ☐no # of days between periods (your cycle)     # of days of flow

|  |  |  |  |
| --- | --- | --- | --- |
| **Color of flow:**☐ pale/light red☐ red☐ bright red☐ dark red☐ dark red/brown | **Amount of flow:****☐** spotting☐ light☐ moderate☐ heavy☐ clots | **# of pads/tampons per day:** 1st day 2nd day 3rd day 4th day +days | **Pain and cramping, rate the severity on a scale of 1-5:** before flow during flow after flow |

**Other symptoms related to menses:**

**☐** discharge ☐ PMS ☐ headache ☐ nausea ☐ constipation ☐ diarrhea

☐ swollen breast ☐ increased appetite ☐ decreased appetite ☐ insomnia ☐ skin outbreaks

**Have you ever been diagnosed with**:

☐ fibroids ☐ endometriosis ☐ ovarian cyst ☐ PID ☐ PCOS ☐ STD

**Are you sexually active?**

**Do you practice birth control?** ☐ yes ☐ no If so, what type and how long?

**Do you experience any of the following:**

Breast: ☐ lumps ☐ cysts ☐ tenderness

Urinary tract infections: ☐ yes ☐ no If so, how frequent?

Vaginal infections/ discharges (describe color):

Pain/itching of genitalia?