Paediatric Acupuncture SHONISHIN
New Patient Intake Form
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oriri
ACUPUNCTURE & HERBAL MEDICINE CENTRE

The following information is essential for the diagnostic procedure and will be kept strictly confidential. Try to be as accurate as you can.

Date(D/M/Y): ____/____/____

Child's Name: _____
First Middle Last

Date of Birth (D/M/Y): ____/____/____ Age: _____

Guardian's Name & Relation to the child: _____

Address: _____
Street City Postal Code

Phone (best reached at): _____ **Email:** _____

How did you hear about us? _____

Weight of Infant at Birth _____

Term Length of Pregnancy
( ) pre-term (37 weeks or less): _____ weeks
( ) full-term (38-42 weeks): _____ weeks
( ) post-term (42 weeks or more): _____weeks

Was your delivery ( ) vaginal ( ) c-section

Was the child breast fed? ( )Yes _____ ( )No
How Long?

Does your child have any known life-threatening allergies (to either food or medicine)? ( )Yes _____ ( )No

Does your child have any known contagious diseases at this time?
( )Yes _____ ( )No

Is your child currently taking any medications or supplements?
( )Yes _____ ( )No

Have any close relatives had any of the following conditions?

( )Allergies ( )Asthma ( )Anemia ( )Birth Defects ( )Bleeding Disorder
( )Cancer ( )Diabetes ( )Depression ( )Eczema ( )Glaucoma ( )Hay Fever
( )Heart Disease ( )High Blood Pressure ( )Juvenile Arthritis ( )Kidney Disease
( )Mental Illness ( )MS ( )Psoriasis ( )Stroke ( )Seizures ( )Other _____

Primary Health Concerns:
In your opinion, what are your child's most important health concerns?

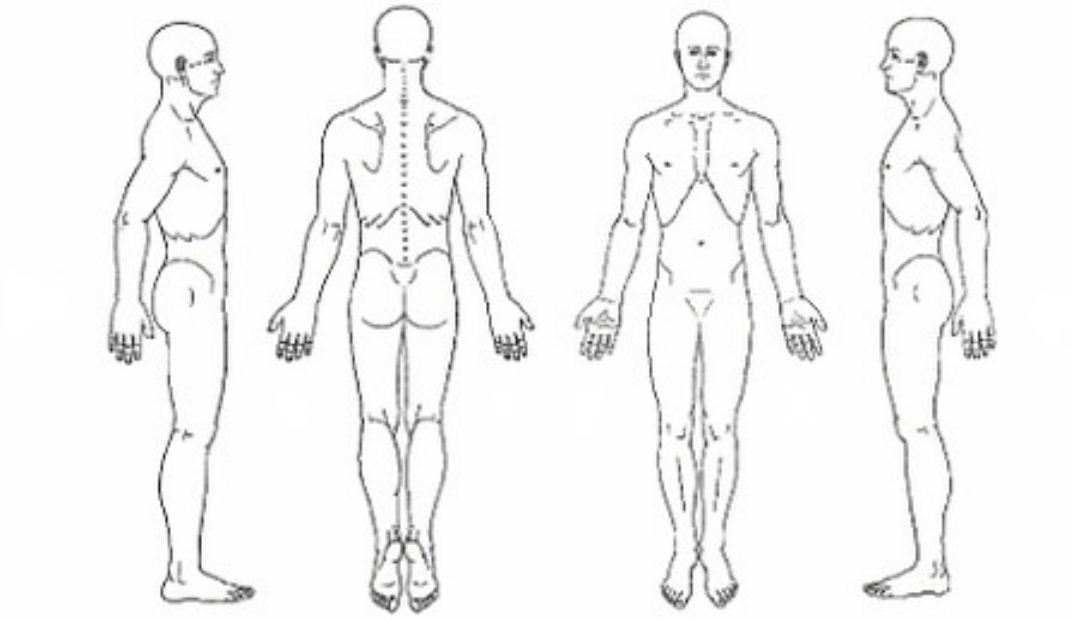
1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Is your child currently experiencing pain? Yes/No

Please indicate any areas of pain/concern on the figures below:



RIGHT BACK FRONT LEFT

General History:

Mouth

Taste in Mouth

- ☐ Tasteless
- ☐ Bitter
- ☐ Sour
- ☐ Salty
- ☐ Dry Damp
- ☐ Numb
- ☐ Other _____

Thirst

- ☐ NOT feeling thirsty after water intake
- ☐ Feeling thirsty with desire to drink plenty of water
- ☐ Feeling thirsty with no or little desire to drink water
- ☐ Feeling dry in mouth with desire to moisten with water
- ☐ Other _____

Teeth & Gums

- ☐ Swollen gums
- ☐ Bleeding gums
- ☐ Toothache
- ☐ Mouth Sores/Canker Sores
- ☐ Other _____

Nose and Throat

- ☐ Sinus Infections
- ☐ Nose Bleeds
- ☐ Hayfever/Allergies
- ☐ Recurring Sore Throat
- ☐ Swollen Glands
- ☐ Hard to swallow
- ☐ Other _____

Eyes

- ☐ Eye pain
- ☐ Spots/Floaters
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ Double vision (diplopia)
- ☐ Dry eyes
- ☐ Red/burning/itchy
- ☐ Other _____

Ears

- ☐ Ringing in the ears (tinnitus)
- ☐ Reduced hearing
- ☐ Earaches
- ☐ Recurring infections
- ☐ Other _____

Head, Neck, Chest, Abdomen and Extremities

- ☐ Dizziness (vertigo)
- ☐ Nausea
- ☐ Neck stiffness
- ☐ Chest pain/tightness
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Flank fullness
- ☐ Stomach fullness/bloating
- ☐ Abdominal fullness/bloating
- ☐ Numbness
- ☐ Itchy
- ☐ Heavy body
- ☐ Lack of Strength
- ☐ Lack of Energy, Sluggish
- ☐ Swollen Ankles
- ☐ Edema
- ☐ Other _____

Urinary

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Urinary incontinence
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Blood in the urine
- ☐ Waking up to urinate
- ☐ Bedwetting
- ☐ Kidney stones
- ☐ Other _____

Bowel Movements

- ☐ Loose or soft stools
- ☐ Constipation
- ☐ Alternate loose/constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools
- ☐ Itchiness or pain in anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Anal fissures
- ☐ Haemorrhoids
- ☐ Other _____

Chills

- ☐ Aversion to wind
- ☐ Aversion to cold
- ☐ Shivers
- ☐ Other _____

Fever

- ☐ Fever. Temperature _____°C
- ☐ Hot flashes
- ☐ Alternate attacks of chills and fever
- ☐ Other _____

Sweats

- ☐ Spontaneous sweats
- ☐ Night Sweats
- ☐ Excessive Sweats on head or neck
- ☐ Sweats on left/right/upper/lower side of the body
- ☐ Excessive sweats on hands and/or feet
- ☐ Excessive sweats on chest
- ☐ Excessive sweats on genital area
- ☐ Other _____

Sleep

- ☐ Restful
- ☐ Light
- ☐ Hard to fall asleep
- ☐ Wake up easily/early
- ☐ Dream disturbed
- ☐ Nightmares
- ☐ Heavy Sleep
- ☐ Hours of sleep per night _____
- ☐ Teeth clenching and grinding
- ☐ Other _____

Appetite

- ☐ Poor appetite
- ☐ Loss of appetite
- ☐ Ravenous appetite
- ☐ Hunger with no desire to eat
- ☐ Cravings of sweet/salty/spicy/sour/bitter
- ☐ Other _____

Skin

- ☐ Itchiness
- ☐ Dryness
- ☐ Mole or lump changes
- ☐ Bruise easily
- ☐ Fine hair/Falling out
- ☐ Nails break easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Hives
- ☐ Other _____

Emotions

- ☐ Relaxed and calm
- ☐ Sad
- ☐ Fearful
- ☐ Depressed
- ☐ Angry/Frustrated
- ☐ Irritated Easily
- ☐ Anxious
- ☐ Stressed
- ☐ Overthinking/Worry
- ☐ Forgetful
- ☐ Manic
- ☐ Impatient
- ☐ Other _____