

TCM – Pediatric Medical History Form

CONFIDENTIAL

Please check boxes, circle or fill in where applicable

To assist in providing you with the best possible care, please fill in this form as accurately as you can. All of the information will be kept confidential in your patient file.

Today's Date: ____/____/____
Month Day Year

Name: _____/_____/_____
Last Name First Name Middle Initial

Patient's Birth Date: ____/____/____
Month Day Year

Height _____ Weight _____

Name of Parent / Guardian:

_____/_____/_____
Last Name First Name Middle Initial

Occupation: _____

Address: _____/_____/_____/_____
Apt#, Street# City Province Postal code

Phone: (home) _____

Phone: (work) _____

Phone: (cell) _____

Email _____

How did you hear about acupuncture and Chinese Medicine at our clinic?

Is your child under the care of a physician now? If yes, for what? _____

What concerns brought you into the clinic today: _____

What, if any, are the present symptoms: _____

Has your child ever been treated with Traditional Chinese Medicine?

Yes: _____ No

Are you currently utilizing any other forms of health care?

Yes: _____ No

Is your child currently taking any prescription or non-prescription drugs?

Yes: _____ No

Does your child take any vitamins, minerals or herbs?

Yes: _____ No

Please complete the sample menu according to an average day.

Morning: _____

Noon: _____

Evening: _____

Snacks (when and what):

Does your child eat or drink the following (if so, how often):

Juice _____

Breads _____

Pop _____

Raw vegetables _____

Ice cream _____

Fruit _____

Peanut butter _____

Red meat _____

Milk _____

Fish _____

Cheese _____

Sweets and sugar _____

Number of doses of antibiotics your child has taken:

during the past 6 months _____ during their lifetime _____

How do you rate your child's energy level: /10 (10 being high and 0 low)

How do you rate your child's average stress level? (please circle one)

None Slight Moderate Severe

Does your child exercise? What type of exercise and how often?

Has your child ever been hospitalized and /or treated for any serious condition or surgeries?

Yes No

If yes, briefly explain for what condition or reason and the year in which your child was hospitalized: _____

Is your child experiencing any of the following conditions (please check all that apply)?

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="radio"/> jaundice | <input type="radio"/> asthma | <input type="radio"/> colic |
| <input type="radio"/> cold sores | <input type="radio"/> tonsillitis | <input type="radio"/> ADD/ADHD |
| <input type="radio"/> scarlatina | <input type="radio"/> impetigo | <input type="radio"/> nosebleeds |
| <input type="radio"/> rhinitis | <input type="radio"/> fever | <input type="radio"/> conjunctivitis |
| <input type="radio"/> pneumonia | <input type="radio"/> ear infections | <input type="radio"/> bedwetting |
| <input type="radio"/> strep throat | <input type="radio"/> measles | <input type="radio"/> epilepsy |
| <input type="radio"/> oral thrush | <input type="radio"/> mumps | <input type="radio"/> tourettes |
| <input type="radio"/> allergies _____ | <input type="radio"/> canker sores | <input type="radio"/> arthritis |
| <input type="radio"/> rubella | <input type="radio"/> eczema / skin problems | <input type="radio"/> other _____ |
| <input type="radio"/> bronchitis | <input type="radio"/> diphtheria | |

Has your child been immunized for the following (please check all that apply):

- | | | |
|----------------------------------|-------------------------------|-----------------------------------|
| <input type="radio"/> diphtheria | <input type="radio"/> polio | <input type="radio"/> chicken pox |
| <input type="radio"/> tetanus | <input type="radio"/> measles | <input type="radio"/> mumps |
| <input type="radio"/> pertussis | <input type="radio"/> rubella | <input type="radio"/> other _____ |

Prenatal History

Were any medications used during pregnancy? What kind?

Were any medications used during labour / delivery? (please list)

Was labour induced? Yes No

Was your child at any point in an intra-uterine constraining position:

breech transverse lie (side lying) face / brow presentation

Was the delivery vaginal? Yes No

Was the delivery C-section? Yes No

Was it **planned** C-section or **emergency**? Yes No

Were any of the following used during delivery?

forceps vacuum extraction other _____

Were there any complications during delivery?

Yes: _____ No

Was your child breast fed? Yes No

Did you formula feed? Yes No

What type of formula? _____

When did you introduce your child to:

solid food _____ cow's milk _____

Does your child have any food sensitivities?

Yes _____ No

I certify that I have completed the above to the best of my knowledge and consent to acupuncture treatment.

PATIENT'S / PARENT'S / GUARDIAN'S SIGNATURE:

_____ Date: _____

Office Fee Policy

TCM / ACUPUNCTURE

1. Initial Consultation: \$140 (includes HST)
2. Subsequent Visits: \$80 (includes HST)

Missed Appointment Fee:

PATIENTS WILL BE CHARGED FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

Payment is due when services rendered and may be paid by cash, visa, or debit. If requested, receipts will be issued upon payment. We do not accept B.C. Medicare as payment and will not bill third party visits. Patients with extended health policies that cover acupuncture treatments must collect from their insurance company after payment.

Patient Advisory

During or after an acupuncture treatment certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. No guarantees concerning its use and effects are given and you are free to refuse treatment at any time.

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese herbal substances by a licensed acupuncturist at BodaHealth™.

Signature _____ Date _____