New Patient: Pediatric (12 years and younger)

PATIENT INFORMATION

Today's Date *

mm/dd/year

Patient's Name *

Date of Birth *

mm/dd/year

Age *

Gender *

Parent(s)/Guardian(s) Name(s) *

Preferred Email *

Phone Number *

Street Address *

Street

City

State

Postal Code

Country

Emergency Contact Name, Phone Number and Their Relationship to You: *

Pediatrician and Phone Number *

Date of Last Visit (approximate ok) *

mm/dd/year

Where does your child go to School? Daycare? Stay home? *

How did you find this clinic? *

1.Primary reason you are seeking treatment for your child: *

Has your child been seen by another practitioner for this? *

- Yes
- No

If yes, what type of practitioner and what was the outcome?

If you have other health concerns for your child, please list/describe them here in order of importance: HEALTH HISTORY

Please list any past surgeries, injuries or hospitalizations, including the year:

Please list any known allergies or food sensitivities. If none, please indicate: *

Please list all current medications and supplements taken by your child, both prescription and over-the-counter. If none, please indicate: *

Please check if anyone in your child's family has a history of:

Arthritis
- Child
- Parent
- Sibling

Asthma/COPD
- Child
- Parent
- Sibling

Autoimmune Disease
- Child
- Parent
- Sibling

Blood Disorder/Anemia
- Child
- Parent
- Sibling

Cancer
- Child
- Parent
- Sibling

Diabetes
- Child
- Parent
- Sibling

Digestive Disorder
- Child
- Parent
- Sibling

Drug/Alcohol Abuse
- Child
- Parent
- Sibling

Eating Disorder
- Child
- Parent
- Sibling

Heart Disease
- Child
- Parent
- Sibling

Hepatitis Hypertension

- [ ] Child
- [ ] Parent
- [ ] Sibling

- [ ] Child
- [ ] Parent
- [ ] Sibling

Kidney Disease

- [ ] Child
- [ ] Parent
- [ ] Sibling

Learning Differences/Developmental Delays

- [ ] Child
- [ ] Parent
- [ ] Sibling

Mental Illness/Depression

- [ ] Child
- [ ] Parent
- [ ] Sibling

Seizure Disorder

- [ ] Child
- [ ] Parent
- [ ] Sibling

Stroke

- [ ] Child
- [ ] Parent
- [ ] Sibling

Trauma/Abuse

- [ ] Child
- [ ] Parent
- [ ] Sibling

Thyroid Disease (hyper or hypo)

- [ ] Child
- [ ] Parent
- [ ] Sibling

Tuberculosis

- [ ] Child
- [ ] Parent
- [ ] Sibling

Please check any of the following that currently apply or have applied to your child in the past:

TEMPERATURE

Absence of thirst

- [ ] Past
- [ ] Current

Cold hands or feet

- [ ] Past
- [ ] Current

Cold "in the bones"

- [ ] Past
- [ ] Current

Excessive thirst

- [ ] Past
- [ ] Current

Hot at night

- [ ] Past
- [ ] Current

Night sweats

- [ ] Past
- [ ] Current

Fevers

- [ ] Past
- [ ] Current

EYES, EARS, NOSE, THROAT

Visually impaired Itchy eyes

☐ Past ☐ Past
☐ Current ☐ Current

Sinus infection Hay fever/allergies

☐ Past ☐ Past
☐ Current ☐ Current

Sore throat Swollen glands

☐ Past ☐ Past
☐ Current ☐ Current

Hearing impaired Ear infection

☐ Past ☐ Past
☐ Current ☐ Current

Excessive earwax Mouth sores

☐ Past ☐ Past
☐ Current ☐ Current

Dental problems Teethgrinding MOISTURE

☐ Past ☐ Past
☐ Current ☐ Current

Dandruff Cradle cap

☐ Past ☐ Past
☐ Current ☐ Current

Dry eyes Dry hair

☐ Past ☐ Past
☐ Current ☐ Current

Dry lips Dry mouth

☐ Past ☐ Past
☐ Current ☐ Current

Dry throat Dry nose

☐ Past ☐ Past
☐ Current ☐ Current

Nosebleeds Dry skin

☐ Past ☐ Past
☐ Current ☐ Current

Itching Rashes/eczema/psoriasis

☐ Past ☐ Past
☐ Current ☐ Current

Edema/swelling Pimples/acne

☐ Past ☐ Past
☐ Current ☐ Current

Tumors/lumps Oily hair

☐ Past ☐ Past
☐ Current ☐ Current

Oily skin Weight gain/loss (unexpected) RESPIRATORY

☐ Past ☐ Past
☐ Current ☐ Current

Asthma Bronchitis

☐ Past ☐ Past
☐ Current ☐ Current

Pneumonia Cough

☐ Past ☐ Past
☐ Current ☐ Current

COPD Frequent colds

☐ Past ☐ Past
☐ Current ☐ Current

Phlegm production Shortness of Breath

☐ Past ☐ Past
☐ Current ☐ Current

TuberculosisGASTRO-INTESTINAL

- [ ] Past
- [ ] Current

Belching

- [ ] Past
- [ ] Current

Constipation

- [ ] Past
- [ ] Current

Dry stool

- [ ] Past
- [ ] Current

Withholding stool

- [ ] Past
- [ ] Current

Diarrhea

- [ ] Past
- [ ] Current

Excessive hunger

- [ ] Past
- [ ] Current

Foul-smelling stool

- [ ] Past
- [ ] Current

Gas/bloating

- [ ] Past
- [ ] Current

Hemorrhoids

- [ ] Past
- [ ] Current

Hernia

- [ ] Past
- [ ] Current

Indigestion/heartburn

- [ ] Past
- [ ] Current

Nausea

- [ ] Past
- [ ] Current

Vomitting

- [ ] Past
- [ ] Current

Poor appetite

- [ ] Past
- [ ] Current

Pain/crampsPain with bowel movement

- [ ] Past
- [ ] Current

Past

- [ ] Current

Rectal painTired after bowel movement

- [ ] Past

Past

☐ Current ☐ Current

Colic Jaundice as babyENERGY

☐ Past ☐ Past
☐ Current ☐ Current

Bleed, bruise easilyBlood pressure high or low

☐ Past ☐ Past
☐ Current ☐ Current

Irregular heartbeatCongenital heart defect

☐ Past ☐ Past
☐ Current ☐ Current

Chest painDizziness, light headedness

☐ Past ☐ Past
☐ Current ☐ Current

Headaches/migrainesBody or limbs weak, heavy

☐ Past ☐ Past
☐ Current ☐ Current

Fatigue Energy drop during the day

☐ Past ☐ Past
☐ Current ☐ Current

Difficulty concentratingADD/ADHD

☐ Past ☐ Past
☐ Current ☐ Current

Wired or ungrounded feelingLearning difficulties

☐ Past ☐ Past
☐ Current ☐ Current

Behavioral difficultiesORTHO-NEURO

☐ Past
☐ Current

Muscle tightness
- [ ] Past
- [ ] Current

Pain/growing pain
- [ ] Past
- [ ] Current

Broken bone
- [ ] Past
- [ ] Current

Numbness/tingling
- [ ] Past
- [ ] Current

Seizures
- [ ] Past
- [ ] Current

Tremors
- [ ] Past
- [ ] Current

Paralysis
- [ ] Past
- [ ] Current

SLEEP

Difficulty falling alseep
- [ ] Past
- [ ] Current

Waking during night
- [ ] Past
- [ ] Current

Nightmares
- [ ] Past
- [ ] Current

Night terrors
- [ ] Past
- [ ] Current

Restless sleep
- [ ] Past
- [ ] Current

GENITO-URINARY

Genital pain/itching
- [ ] Past
- [ ] Current

Yeast infection
- [ ] Past
- [ ] Current

Urinary tract infection
- [ ] Past
- [ ] Current

Frequent urination
- [ ] Past
- [ ] Current

Urgency to urinate
- [ ] Past
- [ ] Current

Pain/burning on urination
- [ ] Past
- [ ] Current

Current Current

Blood in urine
- Past
- Current

Incontinence, beyond toilet training
- Past
- Current

Bedwetting
- Past
- Current

Atypical genitalia
- Past
- Current

EMOTIONS - please check those which your child expresses or you observe frequently:
- Anger
- Irritability
- Anxiety
- Worry
- Obsessive thinking
- Sadness
- Grief
- Depression
- Joy
- Fear
- Timidness/shyness
- Indecisiveness

VACCINATIONS

Has your child been vaccinated? Please describe your vaccine schedule and any reactions to vaccines:

BIRTH

What type of birth did your child experience? Please check all that apply:
- Home
- Midwife
- Birthing Center
- Medical Doctor
- Hospital
- Cesearan Section
- Water Birth
- Doula
- Other

If you checked "other," please describe:

Please describe any medical procedures, if any, used during the birth:

Please describe any complications that may have occurred during the birth:

Please describe the pregnancy of this child. Include any physical complications as well as any emotional issues/stressors that may have arisen during the pregnancy:

Is (was) your child breastfed or formula fed? *

- [ ] Breastfed only
- [ ] Formula only
- [ ] Both

If breastfed, until what age? If formula fed, what brand of formula was/is used?

Was/is the formula soy, cow milk or goat milk based? What was the first solid introduced, and at what age?

Please describe the types of food your child eats regularly:

Breakfast * Lunch *

Dinner * Snacks *

Please describe any restricted diet your child follows now or in the past: *Does your child get daily exercise? If so, what and for how long? *

Please describe an average day of activities for your child: *

Please describe the living arrangements for your child, including circumstances such as joint custody, co-sleeping, siblings, etc. *

What are your expectations and/or hopes for the outcome of this treatment? *

Please provide any additional information about your child that was not covered in this form: Please sign here *

Signature

Today's Date *

Today's Date *

mm/dd/year

Patient Portal Link: https://acusimple.com/access/4577/#/portal/forms/91346/