

OREGON CITY ACUPUNCTURE

619 Madison St #110 Oregon City, OR 97045 503-653-1468

Date _____ Office ID # _____

Child's Name _____ M ____ F ____ DOB _____ Age _____

Mother's Name _____ Living with child (Y)__(N)___

Phone (home) _____ (work) _____ (cell) _____

Father's Name _____ Living with child (Y)__(N)___

Phone (home) _____ (work) _____ (cell) _____

Home Address _____

Child's School Grade _____ Favorite subject _____ Problems at school _____

Pediatrician _____

City/State _____ Phone _____

Reason for Visit Today _____

ALLERGIES Substance Reaction

MEDICATIONS current- name – dose

MEDICAL HISTORY Please check if the child has had any of the following:

Anemia
Asthma
Birth Defects
Breathing problems
Bronchitis /
Bronchiolitis
Bronchopulmonary
dysplasia (BPD)
Chicken pox
Hepatitis
Immune deficiency or HIV
Measles
Mumps
Prematurity
Pneumonia
Rheumatic Fever
Sickle Cell Disease
Whooping Cough
Other

EYES

Crossed or wandering
Eye irritation
Headaches
Vision problems

HEARING/SPEECH

Difficulty hearing
Earache
Ear infections
Hoarseness
Speech problems

NOSE/THROAT/CHEST

Difficulty breathing
Difficulty swallowing
Frequent colds
Hoarseness
Mouth breathing
Nosebleeds
Persistent cough
Sinus problems
Sore throats
Tonsil infections
Wheezing

CARDIOVASCULAR

Breathing problems
Chest pain
Irregular heartbeat

GENERAL

Chills
Depression
Dizziness
Fainting
Forgetfulness
Headaches
Loss of sleep
Mood swings
Sweating
Nervousness
Numbness
Tiredness
Weight loss or gain

SKIN

Bruises easily
Change in moles
Hives
Itching
Rash
Scars
Sores that won't heal

GASTROINTESTINAL

Appetite problem
Bloody or dark stools
Constipation
Diarrhea

Excessive hunger
Excessive thirst
Nausea
Rectal bleeding
Stomachaches
Vomiting
Worms
Other

DENTAL

Bleeding gums
Grinding teeth
Thumb sucking
Last dental checkup
Date: _____

GENITO-URINARY

Bed wetting
Blood in urine
Diaper rash, persistent
Discharge from vagina or
penis
Frequent urination
Painful urination
Unusual urine odor

MUSCLE/JOINT/BONE

Broken bones or sprains
Coordination problems
Posture problems
Pain, weakness, swelling
in:
Hands Arms
Shoulders
Feet Legs Hips
Neck Back

OTHER

Behavior problems
Blood transfusions
Drug use
Learning difficulty
Obesity
Sexual activity
Smoking

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Pt name. _____ ID _____

HOSPITALIZATIONS

Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____

INJURIES / SURGERIES

Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____

PRENATAL HISTORY

Delivery was (check all that apply):

Premature _____ Normal _____ Birth Weight: _____ Length: _____
Early _____ Induced _____ Discharge Weight: _____
On Time _____ Prolonged _____ Days in Hospital: _____ Feeding:
Late _____ C section _____ Delivering Physician: _____ Breast Bottle Both
Mother's Age at Delivery _____

Describe any relevant details of birth: _____

FAMILY HISTORY

Age General Health:
Father _____

Mother _____

Siblings Age Health At home

Other

How old is your home? _____
Are there any significant changes or stressors at home currently? _____
Is your water fluoridated? (y) (n)
Is there cigarette/pipe smoke in the home? (y) (n)
Are there pets in the home?
List: _____
How much alcohol use:
Daily _____ Weekly _____ Amount _____

Check if anyone in the family had/has any of the following:

- | | | |
|----------------------|----------------------------|----------------------|
| Alcoholism | Developmental delay | Lung disease |
| Allergies | Emphysema | Mental illness |
| Asthma | Genetic defects | Muscle disorders |
| Arthritis | Hearing or vision problems | Seizures/convulsions |
| Birth defects | Heart disease | Sickle cell anemia |
| Blindness | Hemophilia | Skin disease |
| Bone/joint disorders | HIV/AIDS | Stroke |
| Cancer | High blood pressure | Thyroid problems |
| | Kidney disease | Tuberculosis |

This is to certify that I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect information about my child's health and symptoms could place my child's health at risk.

Name of Parent/Guardian Signature of Parent/Guardian Date

Interviewer's Signature Date