Regenerative Holistic Wellness

Pediatric Intake Form

All Medical Information is confidential.

I. General Information.

Name of Child: _____
Date:_____
Name of Parent(s)/Legal Guardian(s):
_____
Occupation(s):
_____
Parents are (circle): Married Separated Divorced Living Together Other: _____
Address: _____ City/Zip: _____
Phone: (home) _____ (cell) _____ (work)
_____
Email: _____
Child's Date of Birth: _____ Age: _____ Height: _____
Weight:_____
Sex (m/f): _____ Grade of School: _____
Child's Primary Care Provider/Contact Information:
_____
Emergency contact name & phone number:
_____
How did you hear about us?
_____
Reasons for your visit: (1)
(2)
(3)
What initiates the symptoms?
_____
What makes them better? _____
What makes them worse? _____
Additional comments:

II. Pregnancy and Birth

Child is yours by (circle): Birth Adoption Stepchild Other: _____
Mother's age at conception: _____ Did she have other children already? _____
Health during pregnancy (circle all that apply):
Smoking Recreational Drugs
Preeclampsia Diabetes Emotional Stress
Vaginal Birth Coffee Nausea/Vomiting Traumatic Birth
Location of birth:
_____
If the birth was difficult, please explain:
_____
_____
Describe any interventions at birth including caesarean section and/or use of anesthesia: _____
_____
Health of baby at birth:
_____
Gestational age at birth: _____ Birth weight: _____ Birth length: _____
Additional Comments:

III. Health History of Child
General Information.
Health issues during newborn period:
_____
Child breast fed (circle): Yes No If yes, for how long? _____
When was solid food introduced?
_____
Food or feeding problems:
_____
When did the child walk: _____ Talk: _____ Develop teeth: _____
Additional comments:

Vaccination History.
Please circle all applicable vaccinations.
Are you currently up to date on vaccinations: Y or N
Please note any adverse reactions to vaccinations:
_____
Additional comments:

System Overview.
Please circle all that apply.

Jaundice as baby	Diarrhea	Hyperactivity
Cradle cap	Constipation	Nightmares
Eczema/Psoriasis	Finicky eating	Bed wetting
Colic	Stomach aches	Tantrums
Chronic sniffles	Anemia	Epilepsy/Seizures
Allergies	Autism	Depression
Asthma	Growing pains	Early puberty
Very sweaty	Poor teeth	Emotional Concerns
Diaper rash	Fears/phobias	Diabetes

Please describe your child's stools:
_____
Additional comments:

Medication/Supplements.
List ALL medications (from the drugstore and/or prescription) your child is on now:
_____
_____
_____
_____
List all supplements/vitamins your child is on now:
_____
_____
_____
_____

Allergies.
Is your child allergic or hypersensitive to any:
Drugs? _____
Foods? _____
Animals? _____
Environmental Factors?
_____

Diet.
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Is there anything your child does NOT eat?
_____
Additional comments:

Previous Medical History.
YES (Y) indicates the child gets the problem regularly; **NO (N)** indicates the child never had the problem;
PAST (P) indicates the child had the problem in the past but not recently. Please circle the correct
answers for your child.
Ear Infections: Y N P If has had, how many total: _____
Colds: Y N P If has had, how many total: _____
Strep Throat: Y N P If has had, how many total: _____
How many times has the child taken antibiotics:
_____
Hearing tests normal: Y N Not tested Vision tests normal: Y N Not tested
Speech impediments: Y N P Learning impediments: Y N P
Additional Comments:

V. Social History of Child.
Are both parents living in the home? Yes No
Names and ages of siblings, if any:
_____
Pets: _____
Recent Travel: _____
Recent life changes:
_____
Does you child attend school? Yes No If yes, what grade?
_____
Any concerns about school?
_____
Sports/activities:
_____
Any particular household stressors your child has witnessed or gone through:

Is important to you or your family to:
Avoid medications: Y or N
Include mindfulness and relaxation practices: Y or N
Use the gentlest medicine available: Y or N
Model healthy behavior for your child: Y or N
Would you like more information on holistic health options: Y or N

I have provided correct and complete information to the best of my knowledge.

_____

_____

Patient's or Guardian's signature Date

Regenerative Holistic Wellness
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Asian body work and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Regenerative Holistic Wellness LLC I understand that acupuncturists practicing in the state of MD are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I am licensed and certified in the state of Maryland to
therapeutic bodywork, herbal medicine, and nutrition counseling

Signature: _____Date:_____

Printed Name: _____