Sacred Meridian Acupuncture
Confidential Patient Information Sheet (Pediatric)

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Name:______________________________________

Gender:___________________ M F

Date of birth__________________ age:______

Address:____________________________________

Parents phone number hm:____________________cell:______________________

Email:______________________________________

Name of doctor or pediatrician:________________________last time seen________

Emergency contact:___________________________________

How did you hear about me?____________________________

Health concerns for your visit today:____

____

____

History and details of
concerns:____

____

Has your child been seen by another practitioner for this? ___ Yes ___ No
If yes, what was the outcome? ____

____

____

Has your child had acupuncture or other holistic / complementary treatment before? If so, for what reason and what type of treatment?____

____

Major Medical Conditions – Please list conditions and/or surgeries and year of occurrence	
Date	Condition/Surgery

Please mark any medications used:

Now	Past		Now	Past	
___	___	Aspirin	___	___	Decongestants
___	___	Tylenol	___	___	Anti-histamine
___	___	Antibiotics	___	___	Other____
___	___	Ibuprofen			

List any medicine allergies____
List all current herbs, supplements, vitamins or homeopathic remedies given:
____

____

Medical history (circle)

chicken pox scarlet fever tonsilitis, approx. # of times _______

measles pneumonia ear infections, approx # of times _______

mumps frequent colds strep throat, approx. # of times _______

rubella rheumatic fever other ____

Has your child had any of the following?
If yes, please list when, where and the results:

Injuries/surgeries/hospitalizations:
____
Psychological evaluation
____
Hearing test
____
Speech/language test

Has your child been immunized? yes no

Any adverse reactions? Y N if yes, what? ____

Family History
(If patient is adopted or under guardianship, please complete family history as much as possible)

heart disease __ mental illness __ allergies __ asthma __

hypertension __ diabetes __ birth defects __

cancer __ arthritis __ tuberculosis __

Other relevant family history:
____

Prenatal:
List previous pregnancies by natural mother and any miscarriages or complications:
____
____

Mother's age at birth _________

Please check any of the following experienced during pregnancy:

Bleeding __ nausea __ physical or emotional trauma __

Illnesses __ hypertension __ cigarette, alcohol, or drug consumption __

Medications __ diabetes __ thyroid problems __

Other:____

Birth:
Term: Premature ___ Full _____ Late _____ Length of labor ________ Complications Y N
Birth weight ___________ Length at birth ___________ Delivered:Vaginally__ Caesarian__

Did your child have any of the following problems shortly after birth?

rashes __ birth injuries __ blue baby __

jaundice __ seizures __ cerebral palsy __

colic __ fever __ birth defects __ torticollis (a symptom defined by an abnormal, asymmetrical head or neck position, which may be due to a variety of causes) __

Other____

General:
First year sleep patterns:____
Current sleep patterns: ____
Age began: Sitting _________ Crawling _________Walking _________ Talking _____________

Child's interests: ____

Siblings Y N if yes, how many and what age(s)?

____

Does your child like to interact with other children? Y N

List any pets: ____

Please check any symptoms your child has:

Hives __ burning urine __ bloody urine __ eczema __

cries easily __ bleeding gums __ heart murmur __ nervous __

nose bleeds __ vomiting spells __ sleep problems __ asthma __

acne __ anemia __ night sweats __ high fevers __

jaundice __ sensitive to light __ chronic rash __ stomach aches __

diarrhea __ hearing loss __ easy bruising __ sore throats __

bedwetting __ no appetite __ body/breath odor __ constipation __

nightmares __ frequent colds __ bleeding tendency __ wheezing __

unusual fears __ joint pain __ excessive fatigue __ cough __

dizzy spells __ hair loss __ frequent urination __ allergies __

Other: ____

Has your child had known exposure to: heavy metals __ solvents/chemicals__plastics__

Was your child breastfed? Y N If given formula, what kind? milk__ soy __

Age began solid foods _________ Which foods?________________________________

Does your child have any known food intolerances?

____

Food likes:

____

Food dislikes:

____

Please describe your child's typical daily diet:

Breakfast:

____

Lunch:

____

Dinner:

____

Snacks:

____

To drink:

Consent and Cancellation policy:

Shonishin is a technique that involves non insertive gentle stimulation over meridians of the body, to help increase the vital energy of the child while strengthening their constitution. Please take note that your child's temperature **may** temporarily rise for the rest of the day. Loose stool **may** also be a result of the treatment and the child may be sleepy and relaxed after the session. These are normal physiological responses to the system because of the increase blood flow to the body. Please inform me prior to the next treatment if it continues or if there is any concern.

I , ___________________confirm that I have read and understand the above information , and herby consent to receiving treatments from this clinic. I understand I can refuse treatments at any time and am financially responsible for all the treatments received. I understand the practitioner may review my medical records and lab reports, but all my records will be keep confidential and will not be released at any time without my written consent.

Cancellation Policy:

If you need to cancel an appointment a minimum of 24 hours advance notice is required. This will make it possible to make your time available for another client and to avoid a cancellation fee.
Note: Should an appointment be cancelled less than 24 hours in advance you will be charged 50% of your scheduled fee.
Should an appointment be missed entirely without any notice , the full appointment fee will apply.
Thank you for your consideration and understanding.

Date:_______________

Full name:________________________

Parent/Patient signature: ______________________________

Thank you for your time and effort. I look forward to helping your child in any way that I can.

If there are any questions or concerns please feel free to discuss them, I want to make this visit a pleasant and relaxing experience for you.