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Acupuncture Clinic of Napa

PEDIATRIC REGISTRATION FORM

Name_____**Nickname**_____

Birth Date _____ **Sex M F**

Child live with _____
(write Mother, Father, Parents, Guardian, etc.)

Who spends more time caring for child? _____

Address _____
Street City Zip Phone

Change of address _____
Street City Zip Phone

Mother's Name_____**Address** _____

Father's Name _____**Address** _____

Medical Insurance _____**Address** _____

Child's School _____**Address** _____**Phone**_____

Occupation of parents/Guardian _____

Names and ages of child's siblings _____

List any drug allergies or reactions to medications _____

_____

BIRTH HISTORY

Place of birth _____
(home or name of hospital) City State

Birth weight _____

If the child's mother had any of these problems during her pregnancy with this child check YES, if unsure leave blank

Yes	No		Yes	No	
			☐	☐	Was prenatal care received before the sixth month of pregnancy?
☐	☐	High blood pressure	☐	☐	Was this child born premature?
☐	☐	Diabetes or sugar in urine	☐	☐	Was the birth difficult?
☐	☐	Albumin or protein in urine	☐	☐	Was the baby born with forceps, cesarean, or breach? (circle)
☐	☐	Urinary infection	☐	☐	Did the baby have any problems at birth or need help to start breathing?
☐	☐	German (3-days) measles	☐	☐	**Did the baby remain in the hospital longer than the mother?**
☐	☐	Gonorrhea or syphilis	☐	☐	**Was the baby breastfed?**
☐	☐	Drug or drinking dependence	_____		**Until what age?**
☐	☐	Frequent cigarettes			
☐	☐	Other problems or treatment for illness_____			

MEDICAL HISTORY

If this child has ever had the following problems, check YES, if unsure, leave blank.

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Hospitalization or operations
☐	☐	Blood disorders (anemia, etc.)	☐	☐	Measles (10 day)
☐	☐	Chicken pox	☐	☐	Mumps
☐	☐	Convulsions or fits	☐	☐	Pneumonia
☐	☐	Croup	☐	☐	Pheumatic Fever
☐	☐	Eczema	☐	☐	Scarlet Fever
☐	☐	Frequent bronchitis	☐	☐	Whooping cough
☐	☐	German Measles	☐	☐	Worms

Please check the immunizations this child has had and, if you can, write the year they were last given.

☐	_____	DPT (dipheria, pertussis, tetanus	☐	_____	Mumps
☐	_____	Tetanus	☐	_____	Rubella
☐	_____	Small pox	☐	_____	Polio
☐	_____	Measles	☐	_____	Other

HEALTH QUESTIONNAIRE

If this child has ever been bothered with any of the following problems, check YES.

Yes	No		Yes	No	
☐	☐	Frequent Headaches	☐	☐	Pain or crying when urinating
☐	☐	Eye irritation	☐	☐	Brown, black or bloody urine
☐	☐	Eyes crossing	☐	☐	Bedwetting (over 4 yrs. old)
☐	☐	Trouble with vision	☐	☐	Daytime wetting (over 3 yrs. Old)
☐	☐	Wears glasses	☐	☐	Discharge from penis or vagina
☐	☐	Earaches or running ears	☐	☐	Marked increase or decrease in appetite
☐	☐	Difficulty hearing	☐	☐	Weight loss or gain
☐	☐	Pulling or tugging his/her ears	☐	☐	Rashes or swelling after eating certain foods
☐	☐	Speech impediment	☐	☐	Hay fever or allergies in spring, to animals, etc.
☐	☐		☐	☐	Skin rashes or swelling
☐	☐	Dental problems	☐	☐	Itching skin
☐	☐	Sore or bleeding mouth or gums	☐	☐	Warts
☐	☐		☐	☐	Bruises or bleeding problems
☐	☐	Frequent colds	☐	☐	Accidental poisoning
☐	☐	Mouth breathing	☐	☐	Listless or tired
☐	☐	Recurring nosebleeds	☐	☐	Recurrent fever
☐	☐	Recent sore throat	☐	☐	Motion sickness
☐	☐	Hoarse voice	☐	☐	Serious accidents, sprains, broken bones
☐	☐		☐	☐	Shyness
☐	☐	Wheezing or gasping	☐	☐	Frequent nightmares
☐	☐	Coughing spells	☐	☐	Waking often during night
☐	☐	Shortness of breath while walking or playing	☐	☐	Fears
☐	☐	Must squat or hunch down often while playing	☐	☐	Overly clinging
☐	☐	Chest pains	☐	☐	Easily upset, crying
☐	☐	Burping or gas	☐	☐	Temper fits

☐	☐	**Abdominal pain**	☐	☐	**Breaks or throws things**
☐	☐	**Vomiting**	☐	☐	**Fighting**
☐	☐	**Diarrhea**	☐	☐	**Stealing**
☐	☐	**Constipation**	☐	☐	**Lying**
☐	☐	**Itching at anus**	☐	☐	**Nervous or nervous habits**
		Blood with stools	☐	☐	**Special school or classes**
		Must have a special diet	☐	☐	**Problems at school**
		Frequent urination	☐	☐	**Problems with the family**

Additional comments or special problems: _____

_____

_____

Place and (X) in the appropriate column for any illnesses that this child's blood relatives have had. Briefly describe the condition to the right of the boxes

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brothers/ Sisters
Allergies					
Anemia					
Arthritis					
Asthma					
Bleeding Problems					
Cancer or Tumors					
Diabetes					
Digestive conditions					
Drinking or drug problems					
Epilepsy/convulsions					
Genetic diseases					
Headaches					
Heart disease					
High blood pressure					
Kidney disease					
Mental illness					
Respiratory illnesses					
Skin conditions					
Thyroid problems					
Tuberculosis					
Venereal disease					
Other major illnesses					