Irit D. Weir, L.Ac.,M.S.

P:(707)226-8724
F:(707)226-9470

The Acupuncture Clinic of Napa

Pediatric Registration Form

Name:________________________________ Nickname________________________________

Birth Date:________________________________ Preferred Pronouns:________________________________

Child lives with:____

(mother, Father, Parents, Gaurdian, etc..)

Who spends more time caring for child?____

Address:____

Street *city* *state*

Mother's Name:________________________________Address:________________________________

Father's Name:________________________________Address:________________________________

Medical Insurance:________________________________Address:________________________________

Child's School:________________________________Address________________________Phone:_

Occupation of Parents/Gaurdian____

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*

Birth Weight:____

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

Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	Was prenatal care received before the 6th m
☐	☐	Diabetes or sugar in urine	☐	☐	Was this child born premature?
☐	☐	Albumin or protein in urine	☐	☐	Was the birth difficult?
☐	☐	Urinary tract infection	☐	☐	Was the baby born with foreceps,cesarean, c
☐	☐	German (3-day) measles	☐	☐	Did the baby have any problems at birth or r
☐	☐	Gonorrhea or syphilis	☐	☐	Did the baby remain in the hospital longer th
☐	☐	Drug or drinking dependence	☐	☐	Was the baby breastfed? Until what age?___
☐	☐	Frequesnt cigarettes			
☐	☐	Other problems or treatment for illness________________________________			

Irit D. Weir, L.Ac.,M.S.

P:(707)226-8724
F:(707)226-9470

Medical History

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

Yes	No	
☐	☐	Asthma
☐	☐	Blood disorders (anemia,etc..)
☐	☐	Chicken pox
☐	☐	Convulsions or fits
☐	☐	Croup
☐	☐	Eczema
☐	☐	Frequent bronchitis
☐	☐	German measles

Yes	No	
☐	☐	Hospitalization or operations
☐	☐	Measles (10 Day)
☐	☐	Mumps
☐	☐	Pneumatic fever
☐	☐	Scarlet fever
☐	☐	Whooping cough
☐	☐	Worms

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

☐________________ DPT (dipheria, pertussis, tetanus)
☐________________ Tetanus
☐________________ Small pox
☐________________ Measles

☐________________
☐________________
☐________________
☐________________

Health Questionnaire

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

Yes	No	
☐	☐	Frequent Headaches
☐	☐	Eye irritation
☐	☐	Eyes crossing
☐	☐	Trouble with vision
☐	☐	Wears glasses
☐	☐	Earaches or running ears
☐	☐	Difficulty hearing
☐	☐	Pulling or tugging at ears
☐	☐	Speech impediment
☐	☐	Dental problems
☐	☐	Sore or bleeding mouth or gums
☐	☐	Frequent colds
☐	☐	Mouth breathing
☐	☐	Recurring nosebleeds
☐	☐	Recent sore throat
☐	☐	Hoarse voice
☐	☐	Wheezing or gasping
☐	☐	Coughing spells
☐	☐	Easily upset, crying
☐	☐	Temper fits
☐	☐	chest pains
☐	☐	Burping or gas
☐	☐	Listless or tired
☐	☐	Recurring fever
☐	☐	Motion sickness

Yes	No	
☐	☐	Pain or crying when urinating
☐	☐	Brown, black or bloody urine
☐	☐	Bedwetting (*over 4yrs old*)
☐	☐	Daytime wetting (*over 3 yrs ol*
☐	☐	Discharge from penis or vagin
☐	☐	Marked increase or decrease i
☐	☐	weight loss or gain
☐	☐	Rashes or swelling after eatin
☐	☐	Hay fever or allergies in spring
☐	☐	Skin rashes or swelling
☐	☐	Itching skin
☐	☐	Warts
☐	☐	Bruises or bleeding problems
☐	☐	Accidental poisoning
☐	☐	Serious accidents, sprains, bro
☐	☐	Shyness
☐	☐	Frequent nightmares
☐	☐	Shortness of breath while wal
☐	☐	Must squat or hunch down oft
☐	☐	Waking often during night
☐	☐	Fears
☐	☐	Overly clingy

Irit D. Weir, L.Ac.,M.S.
P:(707)226-8724
F:(707)226-9470

Yes	No		Yes	No	
☐	☐	Abdominal pain	☐	☐	Breaks or th
☐	☐	Vomiting	☐	☐	Fighting
☐	☐	Diarrhea	☐	☐	Stealing
☐	☐	Constipation	☐	☐	Lying
☐	☐	Itching at anus	☐	☐	Nervous or r
☐	☐	Blood with stools	☐	☐	Special scho
☐	☐	Must have special diet	☐	☐	Problems at
☐	☐	Frequent urination	☐	☐	Problems wi

Additional comments or special problems: ____

____

Place an (X) in the appropriate column for any illness that this child's blood relatives ha
Briefly describe the condition to the right of the boxes.

	Mother	Father	Maternal Grandparents	Paternal grandparents	Siblings
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					