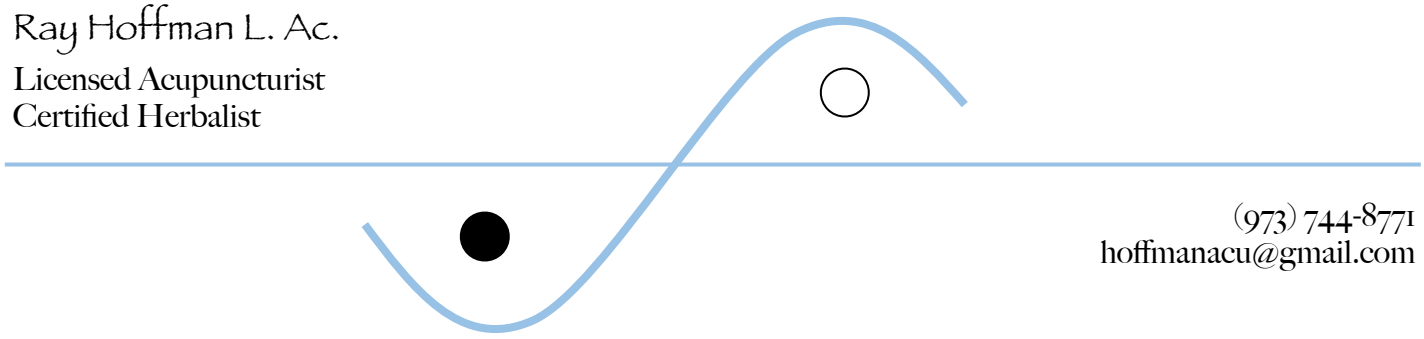
Ray Hoffman L. Ac.
Licensed Acupuncturist
Certified Herbalist



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• PEDIATRIC PATIENT INFORMATION FORM •

Please fill out as completely as possible. The information you include here is confidential, and will be used to help determine the best course of treatment for your child. If you have questions about any items on the form, please ask.

Child's Name			Today's Date
Your Name		Relationship to Patient	
Street Address			
City	State		Zip
Home Phone	Cell Phone	Work Phone	
Email			
Emergency Contact: Name			Phone
Name of Family Doctor			Phone
Sex Male Female	Height	Weight	Birthdate
Has your child received acupuncture or Chinese herbal therapy before? Yes No			
Previous practitioner	When treated?		

Please list the major concern(s) that brought you here today:		
Concern	How long?	Treatment options explored?
1.		
2.		
3.		
4.		
5.		

Please list any medications or nutritional supplements your child is currently taking (use back of sheet if necessary):	
Name of medication/supplement	Dosage

Please describe your child's typical daily eating habits:	
Breakfast:	Dinner:
Lunch:	Snacks:
What are your child's food cravings?	
What are your child's food aversions?	
Does your child have any food allergies? If so, please list:	

Note: Please answer questions on this page in reference to your child's birth family if s/he was adopted.

Pregnancy and Birth

Mother's health issues during pregnancy (check all that apply):

___ bleeding ___ hypertension ___ infertility :
___ nausea ___ diabetes ___ emotional trauma
___ physical trauma ___ thyroid issues ___ medications (list below)
___ other:

Age of mother at birth:_____ Age of father at birth:_____

Gestational age at birth:_____ Birth weight:_____ Birth length:_____

Location of birth (circle one): home hospital birthing center

List any interventions at birth (C-section, induction, etc.)

Length of Labor:

Did the child have any of the following issues shortly after birth?

___ rashes ___ jaundice ___ colic	___ seizures ___ birth injuries ___ fever	___ blue baby ___ cerebral palsy ___ birth defects ___ other

• Family Medical History •

Please indicate any history of the following illnesses or conditions in your child or family:

Illness	Child	Family Member	When?	Illness	Child	Family Member	When?
congenital disorders				psychological disorders			
heart disease				Learning issues			
high blood pressure				seizures			
diabetes				stroke			
thyroid disorder				neurological disorders			
lung problems				substance abuse			
cancer				other (please specify)			

Please list any major illnesses, accidents, surgeries, or hospitalizations (include dates):

Early Childhood History

Formula fed? Yes No Breast fed? Yes No How long?	Age began solid foods Which foods?	1st year sleep patterns

Immunizations (circle any your child has received):

MMR Tetanus Polio Pertussis Diphtheria Hepatitis B Influenza Chicken Pox Prevnar Other _____

Age began:

Sitting_____ Crawling_____ Walking_____ Talking_____

School History

Please describe any particular issues occurring at school (use reverse side if necessary):

Review of Symptoms
Circle all that apply: Indicate frequency by noting:
N = now O = often S = sometimes R = rarely

allergies (other than food	poor appetite	heart murmur	quick to anger	bed wetting
asthma	loose stools	mouth/tongue sores	impulsivity	hearing loss
shortness of breath/ wheezing	constipation	hard to fall asleep	feels better after exertion	phobias
cough	fatigue/low energy	anxiety	earaches	memory issues
catches colds easily	choosy eater	restlessness/easily excitable	headaches	blood in urine
feels sad	frequent worrying/ obsessive thoughts	hyperactivity	light sensitivity	joint pain
nasal/sinus congestion	stomachaches/ vomiting	nightmares	acne	flat feet
skin rashes	frequent gas	speech issues	difficulty sleeping through the night	early puberty
	unsatisfied after eating	bruises easily	oppositional behavior	delayed growth/ development
		easily startled		dental issues