



ABUNDANCE ACUPUNCTURE, INC.

☯ W1185 McCrae Road, Fall River, WI 53932 (920) 484-5000 ☯

"Realize the wonderful benefits of Oriental Medicine"

Pediatric Health History Questionnaire Age 0 to 12

Date: ___/___/___ Parents Names: _____

Child's Name: _____ Age _____

Address: _____ Email address _____

City, State, Postal Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Who does the child live with? Mother Father Siblings # _____ Step-parent Step-siblings # _____

Grandmother Grandfather Aunt Uncle Shared Custody

Is the child in: Homecare Daycare Pre-school School Home Schooled

Prenatal Information

What was the father's age at childbirth _____ What was the mother's age at childbirth _____

Adopted yes no Did the mother receive prenatal care? yes no unknown

Did the mother use any of the following during pregnancy?

Tobacco (first & second hand) Alcohol Recreational drugs Supplements

Prescription medications Over the counter medications unknown

If yes please list _____

Did the mother experience any of the following during pregnancy?

Hypertension Diabetes Bleeding Trauma Stress Eclampsia Thyroid problems

Pre-eclampsia Chickenpox Toxoplasmosis Placenta Previa Severe Vomiting

Delivery Information:

Premature Over-due, number of days _____ Length of labor: _____ Weight at birth: _____

Delivered by: Midwife Home Doctor Hospital

Was the birth: Induced Vaginal C-Section Forceps Suction

Anesthesia yes no

Other: (please describe) _____

Complications: _____

Developmental Milestones:

At what age did your child first;

Sit up _____ Crawl _____ Walk _____ Talk _____ Attend Day Care _____ Use a Cup _____ Feed Self _____

Growth percentile at last check up _____ Date of last check up _____

Was your child breast-fed yes no how long _____ bottle-fed yes no how long _____

Name or types of formulas used _____

Does your child still get a bottle? yes no

At what age were solid foods introduced? _____

What foods were introduced before 6 months (Please list approximate month as well) _____

What foods were introduced between 6 and 12 months (Please list approximate month as well) _____

Please list your child's food allergies / intolerances _____

Are meals: Regular Irregular Fed on demand Grazing

Does your child sleep through the night? yes no number of wake ups per night 1 2 3 more

Does your child wake for diaper changes? yes no urine stool, # of times per night 1 2 3 more

Does your child wake for nighttime feedings yes no

Does your child wake with: Dreams Nightmares Night terrors

Does your child fall asleep easily? yes no

What is your child's bedtime? _____ What time does your child rise in the morning? _____

How many hours does your child sleep at night? _____

How many naps per day? _____ how long are the naps 15 min 30 min 1 hour 1:30 2:00 Longer

Any changes to bowel movements or stool consistency? yes no How long ago?_____

Frequency of daily bowel movements 0 1 2 3 4 more often

Hard to pass yes no with crying yes no

Is stool consistency: Hard and formed Soft and formed Soft and runny, no form Explosive

Foul smelling Normal poop smell Little or no smell Undigested food in stool

Health history:

Check any that your child has or has had in the past:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> ADHD/ ADD | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cardiovascular problems | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Chronic Abdominal pain |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Chronic Diarrhea |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cradle cap (seborrheic dermatitis) |
| <input type="checkbox"/> Croup | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diaper rash | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizzy Spells |
| <input type="checkbox"/> Ear ache | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> High fever |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impetigo | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Learning disorder | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Scabies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Short stature |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Stuffy nose |
| <input type="checkbox"/> Tooth Loss (premature) | <input type="checkbox"/> Trauma | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Yeast infection |

Please explain _____

Developmental or physical concerns, in order of significance to you

- | | |
|---------|---------|
| 1 _____ | 2 _____ |
| 3 _____ | 4 _____ |
| 5 _____ | 6 _____ |

List any Western medical diagnoses _____

Does your child have a special attachment to any item yes no

What is it? _____ Please bring it in if appropriate.