ABUNDANCE ACUPUNCTURE, INC.

☯ 126 N Dickason Blvd, Columbus WI 53925 (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

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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

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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:

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