

Whole Family Wellness Center
New Patient Information (Pediatric)

Patient Information:

Patient Name _____ Today's Date _____
Street Address _____ Apt # _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Office Phone _____
Mobile Phone (____) _____ Email _____
Birth Date _____ Age _____ Gender _____

Referred by: _____

Emergency Contact _____ Relationship _____
Home Phone (____) _____ Office/cell phone _____
Pediatrician's Name _____ Phone _____
Date of last visit _____

Billing and Insurance

Primary Insurance _____ Phone (____) _____
Primary Insurance Address _____
Policy Holder's Name _____ Relationship _____
Policy # / ID# _____ Group # _____

Missed Appointment Policy

If you need to change or cancel your appointment please do so within 24 hours notice. Failure to do so will result in being charged for \$55.

_____ I understand cancellation policy.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Patient Name _____ Date _____

Health History

Reason for office visit _____

Has your child been seen by another practitioner for this? ___ Yes ___ No
If yes, what was the outcome? _____

Has your child had acupuncture or other holistic/natural treatment before? If so, for what reason and what type of treatment? _____

Do you wish for Jill Stevens to act as your child's primary care provider? ___ Yes ___ No

Please check off any of the following symptoms that your child has in the past or is currently experiencing:

past current

- ___ frequent colds
- ___ sinus infection
- ___ production of phlegm
- ___ cough
- ___ cough with blood
- ___ reoccurring ear infections
- ___ hay fever or allergies
- ___ nose bleeds
- ___ asthma
- ___ bronchitis
- ___ pneumonia
- ___ hoarse voice
- ___ difficulty swallowing
- ___ recurring sore throat
- ___ frequent swollen glands
- ___ mouth ulcers
- ___ grinding teeth
- ___ eye glasses
- ___ difficulty hearing

past current

- ___ jaundice as a baby
- ___ abdominal bloating
- ___ abdominal pain
- ___ decreased appetite
- ___ belching
- ___ indigestion
- ___ heartburn
- ___ bad breath
- ___ bleeding gums
- ___ constipation
- ___ frequent diarrhea
- ___ blood in stools/black
- ___ pus in stools
- ___ hemorrhoids
- ___ rectal pain
- ___ change in appetite
- ___ colic
- ___ low energy / fatigue
- ___ bed wetting

past current

- ___ dry skin
- ___ itching
- ___ cradle cap
- ___ rashes, hives, eczema or psoriasis
- ___ acne
- ___ edema
- ___ seizures
- ___ bedwetting
- ___ frequent urination
- ___ blood clotting disorders
- ___ urinary tract infections
- ___ insomnia / nightmares
- ___ anxiety
- ___ often feel afraid
- ___ night sweating
- ___ ADD/ADHD
- ___ behavioral problems
- ___ learning problems

Female Patients:

Age of menses onset: _____

Please check all that apply:

past current

- ___ PMS
- ___ vaginal infections

past current

- ___ breast tenderness
- ___ painful periods

past current

- ___ irregular periods
- ___ abnormal bleeding

Family History (Complete for each family member, placing an X in the appropriate box):

	Child	Mother	Father	Sister	Brother
Allergies					
Blood Disorder / Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder Disorder					
Stomach or Intestinal Disorder					
Drug / Alcohol Use or Abuse					
Tuberculosis					
Heart Disease					
Stroke					
Depression / Mental Illness					
Suicide Attempt					
Age at Death					

Blood Work: When was the last time your child had blood work? What lab tests were done?

Vaccinations

MMR: ___ Yes ___ No ___ Some
 Hep B: ___ Yes ___ No ___ Some
 Chickenpox: ___ Yes ___ No ___ Some
 Hib ___ Yes ___ No ___ Some
 DTaP: ___ Yes ___ No ___ Some
 Influenza: ___ Yes ___ No ___ Some
 Pneumococcal: ___ Yes ___ No ___ Some
 Polio: ___ Yes ___ No ___ Some

Birth

What type of birth did your child have? (please check all that apply)

Home ___ Birthing Center ___ Hospital ___ Birthing Doula ___
 Midwife ___ Medical Doctor ___ Water birth ___
 Other ___ Please describe _____

Please describe any medical procedures, if any, used during the birth _____

Please describe any complications that may have occurred during the birth _____

Please describe the pregnancy of this child. Include any physical complications as well as any emotional issues/stressors that may have arisen during the pregnancy. _____

Major Hospitalizations/Surgeries – Please list any hospitalization or surgeries your child has undergone including date of occurrence

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

Medicines, Herbs, Supplements (Please check any that the patient is currently taking)

- | | |
|--|--|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> antacids |
| <input type="checkbox"/> ibuprofen/motrin | <input type="checkbox"/> fiber / laxatives |
| <input type="checkbox"/> acetaminophen (Tylenol) | <input type="checkbox"/> insulin |
| <input type="checkbox"/> allergy medication | <input type="checkbox"/> cold medicine (Dimetapp, Sudafed) |

other, please list _____

How many times has your child taken Antibiotics? _____

Did you supplement with probiotics (acidophilus)? Yes _____ No _____

Please list any known medication allergies _____

Diet

Is (was) your child breastfed or formula fed? _____ Breastfed only _____ formula only _____ both

Until what age was she/he breastfed? _____

What brand(s) of formula have you used? _____

Was the formula soy, cow milk, or goat milk based? _____

What was solid first introduced? _____

Please describe your child's typical daily diet:

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

Please describe any restricted diet your child follows now or in the past:

Please list any known food allergies/sensitivities _____

Please list your health concerns for your child in order of importance:

Please describe an average day of activities for your child:

Please describe the living arrangements for your child. Including circumstances such as joint custody, co-sleeping, siblings, etc.

What are your expectations and/or hopes for the outcome of this treatment?

Please provide any additional information about your child's health not covered by the above questions (if you need additional room please use the back of this paper).