Well Woman & Family Acupuncture
17 Ranelagh Drive,
Mount Eliza, 3930
Phone: 03 9787 8288

Chinese Medicine Acupuncturist
Gentle & effective technique

Lainey Smallwood Pedley
lainey@wellwoman.com.au

Paediatric Intake

Child's name: Date of birth: Age: Sex:
Date ________________________ Referred by ____
Who is filling out this form (name and relation)? ____

Contacts (in order of preference):

Name ____ Phone
Address ____ (H) ______________________________
____ (W)_______________________________
____ (Mob)_____________________________
Relationship to child
____

Name ____ Phone
Address ____ (H) ______________________________
____ (W)_______________________________
____ (Mob)_____________________________
Relationship to child
____

With whom does the child live?____

How did you hear about W ell Woman Family Acypuncture?

Please list the child's other health care providers:

1.	2.	3.
Name|________________	Name|________________	Name|________________
Practice type|___________	Practice type|___________	Practice type|___________
(____)_______________	(____)_______________	(____)_______________

What are your child's health concerns, in order of importance:
1. ____
2.
3. ____
4. ____

Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations, along with approximate dates:
____
____
____
____
____

Which of the following infections has your child had, and how severely were they affected?
(n = never, m = mild, a = average, s = severe) **immunizations/vaccines do not apply here*

rubella (german measles)
n m a s
measles
n m a s
chicken pox
n m a s
mumps
n m a s

whooping cough (pertussis)
n m a s
strep throat
n m a s
impetigo
n m a s
Roseola
n m a s

mononucleosis
n m a s
ear infections
n m a s
other:

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Please indicate what immunizations (vaccines) your child has had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis B
☐ Tetanus booster; when? ____________________ ☐ "Flu" ☐ Hepatitis A
☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Chicken pox
☐ Meningococcus ☐ Other:

Please indicate any adverse reactions to the above vaccines, with detail:
____
____
____
____

Does your child have any allergies (medicines, environmental, food etc.)? If yes, please explain:
____
____
____
____

Please list all current medications and dosage (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):
____
____
____
____

Please list past prescription medications, and dosage if known:
____
____
____

How many times has your child been treated with antibiotics? ____________________

What screening tests has your child had (blood, hearing, vision, etc.)? Please list:
____
____

Prenatal Health

What was the health of the parents at conception?
Mother Poor Fair Good Excellent Unknown
Father Poor Fair Good Excellent Unknown
What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown
What was the mother's age at child's birth? ____________________
How was the mother's diet during pregnancy? Poor Fair Good Excellent Unknown
Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:
☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting ☐ Unknown
☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma
Other: ____

Did the mother use any of the following during the pregnancy?
☐ Tobacco ☐ Alcohol ☐ Recreational drugs: ____________________
☐ Prescription medications: ____________________
☐ Over-the-counter medications: ____________________
☐ Supplements: ____________________
☐ Other: ____________________

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Birth History

Term length: ☐ Full
☐ Premature: _______________ wks
☐ Late: _____________ wks

Length of labour: ____ Weight at birth: _________________________

Any complications during labour?____

Was the birth (circle all that apply): Vaginal C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐ Brain injuries ___________________________________

☐ Other____

Diet

How was your infant fed?

☐ Breast fed How long? _____________ ☐ Formula. Milk/Soy/Other: _________________ ☐ Other: ____________________

What foods were introduced before 6 months?: ____

____

6–12 months?____

____

____

Did your child ever experience colic? Yes No How severe? mild moderate severe

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?:

____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

Did your child hit each of the appropriate milestones (crawling, sitting, etc.)? Yes No

If no, please explain: ____

Describe your child's current sleep pattern:____

How would you describe your child's temperament? ____

Family History

Please fill out any known medical conditions for the family members indicated on the following tree:

Maternal Grandmother	Maternal Grandfather		Paternal Grandmother	Paternal Grandfather
	Mother		Father	
Siblings		Child	Siblings	

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Environment

Is the child in (circle all that apply): school daycare home care other:_________________________________

What are your child's favorite activities?_________________________________

____

____

Does the child exercise regularly? Yes No How much, how often?:

____

____

How much television does your child watch? __________________ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the child's household smoke? Yes No

Are there animals in the home? Y N

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

____

____

____

____

How would you describe the emotional climate of the child's home?

____

____

Is there anything that you feel is important that has not been covered?

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