

Andrea Kurtz, LAc      Acupuncture and Chinese Herbs

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Today's date \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Name(s) of Primary Caretaker(s) \_\_\_\_\_

Caretaker's Relationship to Child \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Place of Birth \_\_\_\_\_ SS # \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Would you like a reminder before the appointment? \_\_\_\_\_ email or phone reminder? (circle one)

Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Has Your Child Been Treated By Acupuncture or Oriental Medicine Before?:    Yes     No

**Main Problem(s)** that your child would like help with:

\_\_\_\_\_  
\_\_\_\_\_

How long ago did this problem begin (be specific)? \_\_\_\_\_

\_\_\_\_\_

To what extent does this problem interfere with your child's daily activities (school, sleep, etc)? \_\_\_\_\_

\_\_\_\_\_

Has your child been given a diagnosis for this problem: If so, what?

\_\_\_\_\_

What kinds of treatment has your child tried?

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History :**

**Problems with pregnancy or birth** \_\_\_\_\_

**Does your child have all recommended immunizations?** \_\_\_\_\_

**Any reactions to immunizations?** \_\_\_\_\_

**Surgeries** (type of and date) \_\_\_\_\_

**Significant Trauma** (auto accidents, falls, etc) \_\_\_\_\_

**Significant Dental Work** (type and date) \_\_\_\_\_

**Allergies** (drugs, chemicals, foods/result) \_\_\_\_\_

**Medicines** taken within the last two months (drugs, vitamins, herbs, supplements, etc):

Name of Medication/Supplement

Reason for Taking It

\_\_\_\_\_  
\_\_\_\_\_  
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**Has your child taken many courses of antibiotics over her/his life? If Yes, for what reasons?**

\_\_\_\_\_  
\_\_\_\_\_

**Does your child wake at night?** \_\_\_\_\_

**Would you say your child's appetite is good** \_\_\_\_\_, **medium** \_\_\_\_\_, **small** \_\_\_\_\_

**Is your child a choosy eater? In what ways?** \_\_\_\_\_

**Has your child ever been on a restricted diet?** Yes  No  What Kind? \_\_\_\_\_

Please describe your child's **average daily diet**:

Morning \_\_\_\_\_

Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

**Does your child suffer from any of the following?:**

**General**

- Fevers
- Sweat easily
- Sweating after feeding
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Strong thirst (cold or hot)
- Sudden energy drop - what time of day? \_\_\_\_\_
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Change in appetite
- Weight gain
- Weight loss

**Skin and Hair**

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Other hair or skin problems  
\_\_\_\_\_

**Head, Eyes, Ears, Nose, and Throat**

- Dizziness
- Glasses
- Poor vision
- Eye pain
- Color blindness
- Discharge from ears
- Frequent ear infections
- Earaches
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions
- Poor hearing

- Nose bleeds
- Facial pain
- Tonsillitis
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when \_\_\_\_\_  
\_\_\_\_\_
- Other head or neck problems \_\_\_\_\_  
\_\_\_\_\_

**Cardiovascular**

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems \_\_\_\_\_  
\_\_\_\_\_

**Respiratory**

- Cough
- Bronchitis
- Production of phlegm what color \_\_\_\_\_
- Coughing blood
- Pneumonia
- Asthma
- Other lung problems \_\_\_\_\_  
\_\_\_\_\_

Approximately when was your child's last cold or flu? \_\_\_\_\_

**Gastrointestinal**

- Colic
- Nausea
- Constipation
- Black or green stools
- Bad breath
- Abdominal pain or cramps
- Vomiting
- Gas
- Swollen abdomen
- Blood in stools

- Diarrhea
- Belching
- Teething problems
- Other stomach or intestinal problems \_\_\_\_\_  
\_\_\_\_\_

**Genito-urinary**

- Pain on urination
- Blood in urine
- Leakage in the day
- Bedwetting
- Does your child wake up to urinate?  Yes  No.  
How often?  
\_\_\_\_\_
- Any particular color to your child's urine? \_\_\_\_\_
- At what age was your child toilet-trained? \_\_\_\_\_
- Has your child started her menses yet? \_\_\_\_\_
- Does she have any menstrual difficulties or irregularities? \_\_\_\_\_  
\_\_\_\_\_
- Other genital or urinary system problems \_\_\_\_\_

**Musculoskeletal**

- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

**Neuropsychological**

- Seizures
- Areas of numbness
- Bad temper
- Difficulty concentrating

- Vacant
  - Moody
  - Aggressive
  - Temper tantrums
  - Dizziness
  - Lack of coordination
  - Depression
  - Loss of balance
  - Anxiety
  - Developmental disability
  - Late developer
  - Other neurological or  
psychological problems
-

**Comments** (please mention any other problems you would like to discuss):

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**Indicate painful or distressed areas:**

