Avicenna Acupuncture
www.avicennadenver.com

3411.W.38th.Ave
Denver, CO 80211
Phone: 303 803 0675
Email: avicennadenver@gmail.com

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date:_____

Address:_____

City: _____ State: ____ Zip: _____

Parents Name:_____ _____

Telephone (cell): _____ Parent's work #: _____

Parent's email address: _____

Date of Birth: _____ Gender:

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept:

_____

Reason for referral or presenting problems:

_____

MEDICATIONS

NOW: Aspirin ☐ Tylenol ☐ Antibiotics ☐ Ibuprofen ☐ Decongestants ☐
Anti-histamine ☐

PAST: Aspirin ☐ Tylenol ☐ Antibiotics ☐ Ibuprofen ☐ Decongestants ☐
Anti-histamine ☐

MEDICAL HISTORY

Allergies to medicines: _____

Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Pneumonia ☐

Scarlet fever ☐ Frequent colds ☐ Rheumatic fever ☐

Tonsillitis, approx no. of times: ☐ ___

Ear infections, approx no. of times: ☐ ___

Strep throat, approx no. of times: ☐ ___

Other: _____

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Patient's Name: _____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list):

_____

IMMUNIZATIONS

MMR ☐ Measles ☐ Mumps ☐ Rubella ☐ DPT ☐ Diphtheria ☐

Tetanus ☐ Polio ☐ Chicken pox ☐ Flu ☐ Pertusis ☐

Others:

_____

FAMILY HISTORY

Heart disease ☐ Hypertension ☐ Cancer ☐ Mental illness ☐ Diabetes ☐

Arthritis ☐ Osteoporosis ☐ Allergies ☐ Birth defects ☐ Asthma ☐

Tuberculosis ☐ Other significant: _____

PRENATAL HISTORY

Bleeding ☐ Illnesses ☐ Medications ☐

BIRTH HISTORY

Nausea ☐ Hypertension ☐ Diabetes ☐

Previous pregnancies by natural mother, miscarriages, or complications?

_____

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Patient's Name: _____

Mother's health during pregnancy:

Physical or emotional trauma ☐

Cigarettes, alcohol, drug consumption ☐

Thyroid problems ☐

Term: ___ Full Length of labor: _____

Complications: _____

Did your child have any of the following problems shortly after birth?

Premature ☐ Late ☐ Weight at birth: _____

Rashes ☐ Jaundice ☐ Colic ☐ Other: _____

Child's sleep patterns (1st year): _____

Please describe hours of sleep per night and day:

Age began: Sitting ___ Crawling ___ Walking ___ Talking ____

SYMPTOMS

Hives ☐	Cries easily ☐	Nose bleeds ☐	Acne ☐	Jaundice ☐
Diarrhea ☐	Flat feet ☐	Nightmares ☐	Wheezing ☐	Dizzy spells ☐
Fever ☐	Blue baby ☐	Birth defects ☐	Allergies ☐	Cough ☐
Burning urine ☐	Bleeding gums ☐	Vomiting spells ☐	Anemia ☐	
Sensitive to light ☐	Hearing loss ☐	No appetite ☐	Frequent colds ☐	
Joint pains ☐	Bloody urine ☐	Heart murmur ☐	Sleep problems ☐	
Night sweats ☐	Chronic rash ☐	Easy bruising ☐	Constipation ☐	
Body/breath odor ☐	Bleeding tendency ☐	Unusual fears ☐	Excessive fatigue ☐	
Frequent urination ☐	Cerebral palsy ☐	Birth injuries ☐	Seizures ☐	

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Patient's Name: _____

How many bowel movements per day? ___

What quality is it? (please mark all that apply)

Firm☐ dry☐ runny☐ smelly☐ dark brown☐ light brown☐ yellowish, ☐
green☐ no/light smell☐ other: _____

What color is the urine?

Dark yellow☐ light yellow☐ no color☐

DIET

Breast fed: ☐ How long: _____ Formula:☐ Type (milk, soy): _____

Age began solids: _____ Which foods: _____

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Food intolerances: _____

How is your child's appetite?

Good☐ Fair☐ Poor☐

General

Is your child at daycare/preschool/school? Yes☐ No☐

If yes: how many days per week? _____

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Patient's Name: _____

What is you child's energy level?

High ☐ Medium ☐ Low ☐

Describe your child's mood?

Sleepy ☐ Agitated ☐ Restless ☐ Crying ☐ Happy ☐ Needy ☐

Other: _____

What is your main concern regarding your child?

(e.g. not getting enough nutrition, appears unhappy, not keeping up with other kids)

_____

_____

_____

_____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.

PRINT