# NEW PEDIATRIC PATIENT INFORMATION

# Sebastopol Family Acupuncture

Patient Information
Patient's Name_____Today's Date_____
Street Address_____Apt. # _____
City_____ State _____Zip _____
Home Phone (  )
Other Phone (  )_____Email _____
Birth Date_____ Age _____Gender_____

Parent/ Guardian's Name_____

Referred by_____

Emergency Contact _____Relationship_____
Emergency Contact Phone # home (  )_____Office or Cell(____)_____
Physician's Name_____Phone_____
Date of last visit _____

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

Billing and Insurance

Note on Insurance
Payment in full is due at the time services are rendered. $80 per visit plus $40 for new patient. Upon request a Superbill will be provided or insurance will be billed. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance_____Phone (  )
Primary Insurance Address
Policy Holder's Name_____Relationship _____Policy # / ID # _____Group# _____

_Insurance billed please
Superbill requests  _No, thanks!  _ Once a month  _At the end of each treatment

Missed Appointment Policy
If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged $80.

_I understand cancellation policy.

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Please describe your child's birth story including where, who attended, complications, interventions, and medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Vaccinations**

Hepatitis B: Date given : _____ Booster Dates
DTaP: Date given: _____ Booster Dates
MMR: Date given: _____ Booster Dates
Influenza: Date given: _____ Booster Dates
Pneumococcal: Date given: _____ Booster Dates
Chickenpox: Date given: _____ Booster Dates
Hepatitis A: Date given: _____ Booster Dates
Other: Date given: _____Booster Dates

**Diet History**

Please describe your child's eating history including whether or not your child was breast milk fed, formula fed, when solid foods were introduced, what was introduced when

**Infection/ Illness History**

Please describe any illnesses that your child has contracted and when

**Treatment History**

Please describe any antibiotics, medications, and other treatments performed, and over the counter medications that your child has used (including Tylenol etc..)

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Please describe if and when your child got their first teeth and how many he/she has currently

_____
_____
_____

Please list the name of any of the following that are currently being taken:
Western Drugs Herbs Vitamins and Supplements

_____
_____
_____

Medication Allergies _____

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:

_____
_____
_____

Food Allergies _____

Food Sensitivities _____

| past | current | | past | current | | past | current | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | frequent colds | ☐ | ☐ | hyperactivity | ☐ | ☐ | dry skin |
| ☐ | ☐ | croup | ☐ | ☐ | low weight | ☐ | ☐ | ear infections |
| ☐ | ☐ | production of phlegm | ☐ | ☐ | thrush | ☐ | ☐ | itching |
| ☐ | ☐ | cough | ☐ | ☐ | decreased appetite | ☐ | ☐ | rashes, hives ☐ eczema, psoriasis |
| ☐ | ☐ | cough with blood | ☐ | ☐ | belching | ☐ | ☐ | acne |
| ☐ | ☐ | hay fever or allergies | ☐ | ☐ | throw up/ spit-up | ☐ | ☐ | seizures |
| ☐ | ☐ | nose bleeds | ☐ | ☐ | bad breath | ☐ | ☐ | ear infections |
| ☐ | ☐ | asthma | ☐ | ☐ | bleeding gums | ☐ | ☐ | teething |
| ☐ | ☐ | high fevers | ☐ | ☐ | constipation | ☐ | ☐ | food allergies |
| ☐ | ☐ | pneumonia | ☐ | ☐ | frequent diarrhea | ☐ | ☐ | feeding issues |
| ☐ | ☐ | hoarse voice | ☐ | ☐ | blood in stools/black stools | ☐ | ☐ | insomnia |
| ☐ | ☐ | difficulty swallowing | ☐ | ☐ | pus in stools | ☐ | ☐ | anxiety |
| ☐ | ☐ | recurring sore throat | ☐ | ☐ | jaundice | ☐ | ☐ | difficult sleep |
| ☐ | ☐ | frequent swollen glands | ☐ | ☐ | goopy eyes | ☐ | ☐ | night sweating |
| ☐ | ☐ | yeast/ candida | ☐ | ☐ | change in appetite | ☐ | ☐ | ADD/ADHD |
| ☐ | ☐ | nasal discharge | ☐ | ☐ | colic | ☐ | ☐ | behavioral problems |
| ☐ | ☐ | eye glasses | ☐ | ☐ | low energy / fatigue | ☐ | ☐ | learning problems |
| ☐ | ☐ | difficulty hearing | ☐ | ☐ | bed wetting | | | |

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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, etc.

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

Please provide any additional information about the patient or his/her condition not covered by the above questions (if you need additional room please use the back of this paper)