Child's Name: ____________________________________ Date: __________

Parent's Name: ____
Address: _______________________________ City: ___________________
State: ______ Zip: _________ Phone: _______________________ (C, H, W)
Parent's Email:____
Gender: _____ Ethnicity: _____________ Date of Birth: __________ Age: ______

Please list child's **weight:** ________ lbs and **height**: _____ ft____in Date of last physical exam:________________
Name of Pediatrician:________________________ Phone/Address: _______________________________________

In Case of Emergency, Contact _________________________________ Phone: ________________________________

How did you hear about this practice? Personal referral: ____

Google Yelp Acufinder Yahoo Citysearch NCCAOM Other:_____________________

(Please check if yes) M (Mother), F (Father), S (Sibling), (G) Grandparent, (O) Other

	M	F	S	G	O		M	F	S	G	O
Allergies (Environmental)	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	Thyroid Disorder	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	Kidney/UB Disorder	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	Neurological Disorder	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	Heart Disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	Stomach/Intestinal Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	Drug/Alcohol Addiction	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐	☐

Family Health History:

Check if Child has had any of the following:

☐ Jaundice	☐ Impetigo	☐ Eczema
☐ Colic	☐ Fever	☐ ADHD
☐ Febrile seizures	☐ Measles	☐ Epilepsy
☐ Cold Sores	☐ Canker Sores	☐ Mumps
☐ Rhinitis	☐ Oral Thrush	☐ Measles
☐ Allergies (Seasonal)	☐ Hives	☐ Ear Infections
☐ Urinary Reflux	☐ Nosebleed	☐ Tourette's
☐ Strep Throat	☐ Conjunctivitis	☐ Arthritis
☐ Pneumonia	☐ Tonsillitis	☐ Psoriasis
☐ Bronchitis	☐ Bedwetting	☐ Food Allergies: ___________

List any hospitalization(s) & date(s): ____

Major Traumas (car accident, falls, etc.): ____

Has your child been immunized for the following *(Please check all that apply):*

☐ Diphtheria	☐ Rubella	☐ HIB *Haemophilus influenzae* type b
☐ Tetanus	☐ Chickenpox	☐ Rotavirus
☐ Pertussis	☐ Mumps	☐ Flu
☐ Polio	☐ HepA	☐ HPV
☐ Measles	☐ HepB	☐ Other: ______________________

Any side effects from immunizations: ____

Has your child taken antibiotics before? ☐ Yes ☐No Number of times on Antibiotics: _______

Has your child taken any other medications **in the past**? ☐ Yes ☐No Please list any **previous** medications, supplements and herbs: ____

Please include a sample menu according to an average day:

Breakfast	
Lunch	
Dinner	
Snacks	

How often does your child eat/drink the following foods:

☐ Juice	☐ Milk
☐ Ice Cream	☐ Cheese
☐ Peanut Butter	☐ Breads
☐ Raw Vegetables	☐ Sweets

Was the child breast fed? ☐ Yes ☐No How and when were solid foods introduced? _______________________

Does your child suffer from any digestive ailments? ☐ Yes ☐No Please describe: _________________________

How often does your child have a bowel movement? ____

Please describe if there were any complications during the pregnancy & delivery: ____________________________
____

Reason for Visit: _______________________________ Current treatments: _______________________________

Current Medications: *Include prescription drugs, Over the Counter drugs, Vitamins, Minerals, Herbs, Dietary (nutritional) supplements* ☐ None

#	Medication Name & Condition Treated	Dose	Frequency	Route
1				☐Oral ☐ Suppository ☐ Injection ☐ IV
2				☐Oral ☐ Suppository ☐ Injection ☐ IV
3				☐Oral ☐ Suppository ☐ Injection ☐ IV
4				☐Oral ☐ Suppository ☐ Injection ☐ IV

Provider reviewed with parent:____ Date: _______________

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

> *I/We, the undersigned, do affirm that (patient)* ______________________________ *has been advised by (L.Ac.)* __________________________________ *to consult with a physician regarding the condition(s) for which the above named patient seeks acupuncture/herbal medicine treatment.*

Patient Signature:_______________________________________ Date: _____________________

Minor under the age of 18 or otherwise lacks capacity to sign:

Name of Parent/Legal Guardian:____________________________ Relationship to Patient: _____________________

Signature of Parent/Legal Guardian: ____________________________________ Date:_____________________