Paediatric Acupuncture

Patient's name: _____Date of first visit: _____ Age: _____

Date of Birth: _____, Mother's name: _____Father's name: _____

Address: _____Postcode_____

Parent's mobile _____Parent's e-mail address: _____

Child's GP or Pediatrician: _____

Current health concerns:

_____

When did it start _____ when are you most aware of the symptoms _____

What makes it better_____ What makes it worse_____

Please explain briefly what you would like to see as a result of acupuncture treatments?

_____

Other health care providers the child is seeing: _____

Child's birth history (please highlight anything that applies to your child, Y/N or explain below)

Term: Full /Premature/Late; @ _____ weeks, Weight at birth:_____Length of labor _____

Any complications? _____

Birth: vaginal / C-section /Induced / Forceps / Suction / Anesthesia used

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

Birth abnormality; Birth injuries; Blue baby; Cerebral palsy; Seizures; Jaundice; Colic; Fever; Rashes

Other (explain): _____

Feeding /Digestion/ Bowel Movement/ Sleep/ Behavior

Breastfed? yes /no How long ____ Formula yes/ no, If Yes: cow's milk / soy other_____
Any problems with feeding: colicky/ oral thrush/ other _____

Food or environmental sensitivities or allergies _____

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Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Age began solids _____Which foods?_____

Appetite: good/ poor/ picky eater _____ Thirst good /poor_____

How much does your child drink a day: milk_____ juice_____, water_____

Urination frequent/urgent/bedwetting/infections / smelly urine_____

How often does the child open the bowels: regularly/ irregularly; _____x a day

Are the stools hard/ loose, are they shaped like a sausage/ smarties/ smoothie like, are they smelly/ smell of apples/ not too bad; any blood / mucus in the stool

Any abdominal pains: dull/ strong; any nausea/vomiting

Sleep patterns: difficulties going to sleep; needs to be thrown up in the air /bangs head on the pillows; waking up - crying, frightened, hungry; dream disturbed sleep; night terrors; wakes up early i.e. 5 am & wants to play; sleep walking/talking other: _____

Energy levels: lethargic/ sudden collapses of energy/ restless/ good_____

How would you describe your child's temperament? _____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

Does the child exercise regularly? If yes, what kind of exercise, how much, how often?
_____

How much screen time does your child watch _____

Does anyone in the child's household smoke? Y/ N Are there animals in the home? Y /N

Chest and nose: tendency to mucus: see-through/yellow/green, how frequently does your child get colds and coughs/runny nose/blocked nose/chronic phlegm on chest_____

Any childhood illnesses (chicken pox, mumps, scarlet fever, measles, pneumonia, strep throat, impetigo, whooping cough, ear infections, rubella, UTI, chronic cough) other_____

What screening tests has your child had? (Blood, etc) _____

How is child's vision_____ hearing_____ immunity _____any skin problems_____

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Serious Illnesses/ recurring illnesses /Injuries/Surgeries/Hospitalizations (please list):

_____

Please list all current medications (prescription, over the counter, vitamins, herbs, homeopathic etc.)

_____

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

Family History	Mother side	Father side
Heart disease		
Diabetes		
Anemia		
Asthma		
Thyroid Problems		
Kidney Disease		
Birth abnormality		
Celiac disease		
Hypertension		
Eczema		
Cancer		
Allergies		
Mental illness		

Immunization

MMR; Polio; Chicken Pox; Influenza; DTaP; Hepatitis B; Other: _____At suggested age_____ or later/earlier on in life___Any adverse reactions to vaccines: yes/ no If yes, please describe:

_____

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Birth Mother's prenatal history

What was the health of the parents at conception? Mother: Poor /Fair/ Good/ Excellent/ Unknown

Father: Poor/ Fair/ Good/ Excellent/ Unknown Fertility problems/ IVF

What was the health of the mother during pregnancy: Poor /Fair/ Good/ Excellent/ Unknown

Mother's age at childbirth_____ Mother's diet during pregnancy? Poor/ Fair/ Good/ Excellent

Were any of the following experienced during pregnancy?

Anaemia; Bleeding; Physical or emotional trauma/shock; High blood pressure; Nausea/Vomiting; Cigarettes, alcohol, drug consumption; Thyroid problems; Illnesses ; Surgery; Medications; Gestational diabetes; Depression/Anxiety; Overworking; Other_____

Please write anything that you feel is important that has not been covered:
_____

Home life: one partent/ both parents, Siblings _____ relationship _____

Daily life: regular, nursery / school_____x week

School life: ease of separation_____, degree of tiredness after school _____, / end of term_____

Ease with the social side of school_____ability to concentrate in class and doing homework_____

Any learning difficulties_____

Has the child experience any physical or emotional trauma?_____
_____

Is there anything else you think would be important for me to know _____

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Consent Form

Informed Consent for Acupuncture Treatment

I _____ hereby agree and consent to the performance of acupuncture and other procedures on _____. I understand that such procedures may include: acupuncture, Shonishin, acupressure, moxibustion, cupping & Gua-Sha (dermal friction technique), laser pen, exercise therapy and nutritional counselling based on traditional Chinese medical theory.

I will remain in the room with my child for the duration of the treatment.

Acupuncture practiced by a properly trained practitioner is a very safe therapy. Serious side effects from treatment are very rare – less than one per 10,000 treatments. The needles used are single-use, sterile, disposable needles. Your practitioner will follow strict guidelines laid down by the Association of Acupuncture Clinicians (AAC) and developed by the leading experts in the field of skin piercing. Acupuncture treatment is not a replacement for diagnostic medical procedures. An acupuncturist does not diagnose according to Western medical practice, nor should a "Chinese Diagnosis" be considered a replacement for standard medical evaluation or testing.

Data Protection:

Holistic Therapy Ealing is legally required to record essential clinical information that we take from you during the initial consultation and each subsequent appointment to enable us to make an accurate diagnosis of your problem(s) and to formulate an appropriate treatment and management plan. These records are held on paper, not in electronic form, and you may request a copy at any time. We store copies of any medical correspondence in paper form and stored in a locked filing cabinet, accessible only to therapist at the Holistic Therapy Ealing. Statutory minimum storage times for medical records and associated correspondence are seven years after the date of the last appointment. In the case of minor's records must be kept until the patient reaches the age of twenty-five (seven years after reaching eighteen).

Please note that once you have booked an appointment with Holistic Therapy Ealing, it means that the time has been reserved exclusively for you. If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be liable to cover the appointment fee. You can cancel or reschedule an appointment by emailing info@holistictherapyealing.co.uk or texting 07899737421.

By signing below, you agree for _____ to have a treatment and with the above Data Protection & Cancellation policy.

Parent_____ Signature_____ Date_____