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

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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](mailto: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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_