little owl medicine

Treating children while nourishing the family

Little Owl Medicine • 513 NE Schuyler Street, Portland, OR 97212 • 503 312-4223 • www.littleowlmedicine.com

Pediatric Intake Form

Patient's name: _____Date of first visit: _____

Age: Date of Birth (month/day/year): _____/_____/_____ Gender: female male

Mother's name: _____ Father's name:_____

Address: _____ City:_____ Zip: _____

Phone # (home): (_____)_____ Parent's work/cell phone # (_____)_____

Parent's e-mail address: _____

Child's GP or Pediatrician: _____

Current health concerns: _____

MEDICAL HISTORY

Chicken pox ____ Scarlet fever _____ Roseola _____ Mononucleosis _____ Measles _____

Pneumonia _____Strep throat _____ Impetigo_____ Mumps _____ Whooping Cough _____

Ear Infections_____ Rubella _____ Rheumatic fever_____ other (please list) _____

_____

What screening tests has your child had? (blood, hearing, vision, etc)_____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

_____

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

_____

_____

Please list any past prescription medications: _____

_____

IMMUNIZATIONS

MMR _____ Polio _____ Prevnar _____ Chicken Pox _____ H. Influenza B _____ DTaP _____ Influenza _____ Hepatitis B _____ Hepatitis A _____ Other: _____

Any adverse reactions to vaccines: yes no If yes, please describe: _____

_____

FAMILY HISTORY

Heart disease ____ Diabetes____ Birth abnormality ____ Celiac disease ____ Hypertension ____

Arthritis ___Tuberculosis ___ Eczema____ Cancer _____Allergies ____ Mental illness _____ Asthma____

Other: _____

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth? _____ Mother's health during pregnancy? _____

Were any of the following experienced during pregnancy?

Bleeding ____ Physical or emotional trauma ____ High blood pressure____Nausea/Vomiting_____

Cigarettes, alcohol, drug consumption ____ Thyroid problems_____ Illnesses _____ Surgery____

Medications ____ Gestational diabetes____ Depression/Anxiety____ Other_____

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CHILD'S BIRTH HISTORY

Term: Full Premature: _____ weeks Late: _____ weeks Weight at birth:_____lbs, ____ oz.
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

Breastfed? yes no How long? Formula? yes no If Yes: cow's milk soy other

Child's sleep patterns _____

How would you describe your child's temperament?_____

Food or environmental sensitivities or allergies (if known) _____

_____

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

Age began solids _____Which foods?_____

Typical daily diet: _____

_____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

SYMPTOMS (mark Y if current, P significant past symptom)

Hives	Sleep problems	Easy bruising	Frequent colds
Burning of urine	Acne	Motion/car sickness	Bleeding tendency
Bloody urine	Anemia	Diarrhea	Unusual fears
Eczema	Night sweats	Earaches/Infections	Wheezing
Frequent urination	High fevers	No appetite	Joint pains
Cries easily	Stomach aches	Sore throats	Excessive fatigue
Bleeding gums	Sensitive to light	Constipation	Cough
Heart murmur	Chronic rash	Nightmares	Dizzy spells
Nervous	Jaundice	Headaches	Hair loss
Nose bleeds	Body/breath odor	Gas	Other: _____
Vomiting spells	Hearing loss	Canker sores	_____

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

_____

Patient Intake Detailed Information

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EVERY DETAIL IS IMPORTANT

Name: _____ **Date:** _____/_____/_____ **Age:** _____

_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: ____/___ /_____