Mountain Spirit Acupuncture
12201 Pecos Street Suite 100 Westminster, CO 80234
303-929-7334

Patient Health History (Pediatric)

Name: ____ Birth Date: _____/_____/_____ Age: _____

Address: ____ City: ________________ State: _______ Zip: ________

Preferred Phone #: ______________________________________ □ Home □ Cell □ Work Ok to leave messages? □ Yes □ No

How did you hear about **Mountain Spirit Acupuncture?** □ Friend – (Who?) ________________________________ □ Internet
□ Mail-out □ MD □ Other ________________________________

Emergency Contact: ________________________________ Relation: _____________________________ Phone #: __________________

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally and emotionally. Please complete the following questionnaire as thoroughly as possible.

Are you currently receiving health care? □ Yes □ No
If yes, where and from whom? ____
If no, when and where did you last receive health care? ____

MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: ____
Symptoms: ____
____
____

How long have you had this? ____
Is your condition: □ Getting worse □ Staying constant □ Coming & going Have you had this in the past? □ Yes □ No
How did it begin? ____
What aggravates it? ____
What relieves it? ____
What other healthcare practitioners have you seen about this? ____
Type of care given? ____ Was it effective? ___________________________________

SECONDARY COMPLAINT: ____
Symptoms: ____
____
____

How long have you had this? ____
Is your condition: □ Getting worse □ Staying constant □ Coming & going Have you had this in the past? □ Yes □ No
How did it begin? ____
What aggravates it? ____
What relieves it? ____
What other healthcare practitioners have you seen about this? ____
Type of care given? ____ Was it effective? ___________________________________

Are your complaints affecting your ability to work or otherwise be active? □ No effect □ Yes □ Some physical restrictions
□ Need limited assistance □ Need assistance often □ Can't care for self

Is today's visit due to a Motor Vehicle Collision? □ Yes □ No If yes, when? ____
Have you ever had acupuncture before? □ Yes □ No
Do you have any chronic infections diseases? □ Yes □ No If yes, explain: ____
Are you suffering from any chronic illnesses? □ Yes □ No If yes, explain: ____

Significant diseases, injuries, hospitalizations, surgeries, x-ray/CT/MRI/NMR

Reason Date Results (if applicable)

____

____

____

____

Please list any prescription medications, over the counter medications, vitamins or supplements that you are currently taking, and give your dosage.

Medication/Vitamin/Supplement Dosage Frequency Reason

____

____

____

____

____

Please list any foods, drugs, substances or medications you are hypersensitive or allergic to: ______________________

Please check any immunizations that you have had: □ Polio □Tetanus □ Measles/Mumps/Rubella (MMR) □ Pertussis □ Diphtheria □ Hepatitis B □ Influenza □ Other: ______________________

Family History	Mother	Father	Brother(s)	Sister(s)
Age if living				
Health G = Good, P = Poor				
Age at death if deceased				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Stroke				
Mental Illness				

HEALTH HISTORY

When completing the information below, indicate if it is a CURRENT condition (first box) or a PAST condition (second box):

General Symptoms

C / P
- □ □ Poor appetite
- □ □ Large appetite
- □ □ Strongly like cold drinks
- □ □ Strongly like hot drinks
- □ □ Peculiar taste
- □ □ Cravings
- □ □ Sweats easily
- □ □ Night sweats
- □ □ Prolapsed organs

C / P
- □ □ Poor Sleep
- □ □ Dream disturbed sleep
- □ □ Heavy sleep
- □ □ Bodily heaviness
- □ □ Chills
- □ □ Fever
- □ □ Bleed or bruise easily
- □ □ Cold hands or feet

C / P
- □ □ Poor circulation
- □ □ Vertigo or dizziness
- □ □ Fatigue
- □ □ Lack of strength
- □ □ Shortness of breath
- □ □ Muscle cramps
- □ □ Anemic
- □ □ History of Cancer
  What type: _______________ When: ______

Endocrine and Metabolic Disorders

- □ □ Hypothyroidism
- □ □ Adrenal burnout / fatigue
- □ □ Sweats easily
- □ □ Hyperthyroidism
- □ □ Diabetes Mellitus
- □ □ Weight gain
- □ □ Hypoglycemia
- □ □ Night sweats
- □ □ Weight loss

Head, Eyes, Ears, Nose, Throat

C / P

□ □ Headaches
□ □ Migraines
□ □ Facial pain
□ □ Glasses or Contacts
□ □ Poor vision
□ □ Blurred vision
□ □ Eye strain
□ □ Red eyes
□ □ Itchy eyes
□ □ Spots or floaters in eyes

C / P

□ □ Glaucoma
□ □ Night blindness
□ □ Sores on lips or tongue
□ □ Swollen glands
□ □ Dry mouth
□ □ Excessive saliva
□ □ Recurrent sore throat
□ □ Lumps in throat
□ □ TMJ problems
□ □ Teeth problems

C / P

□ □ Grinding teeth
□ □ Sinus problems
□ □ Enlarged thyroid
□ □ Excessive phlegm
□ □ Ear aches
□ □ Ringing in ears
□ □ Poor hearing
□ □ Gum problems
□ □ Eye pain
□ □ Concussions

Respiratory

□ □ Difficulty breathing when lying down
□ □ Shortness of breath
□ □ Tight chest
□ □ Cough Wet or dry (circle one)
□ □ Color of phlegm ____________
□ □ Coughing blood
□ □ Asthma / Wheezing
□ □ Pneumonia
□ □ Frequent colds
□ □ Persistent cough

Cardiovascular

□ □ High blood pressure
□ □ Tight chest
□ □ Chest pain
□ □ Pace maker
□ □ Fainting
□ □ Difficulty breathing
□ □ Heart palpitations
□ □ Low blood pressure
□ □ Irregular heart beat
□ □ Heart disease
□ □ Blood clots
□ □ Other ____________________________

Are you currently taking Coumadin, Warfarin or any other blood thinners? □ Yes □ No

Gastrointestinal

Bowel movements:
Frequency: __________________________
Texture/Form: ________________________
Color: ______________________________
Odor: ______________________________
□ □ Diarrhea
□ □ Constipation
□ □ Laxative use
□ □ Mucous in stool
□ □ Undigested food in stool
□ □ Itchy anus
□ □ Anal fissures
□ □ Black stools
□ □ Bloody stools
□ □ Gas
□ □ Bloating
□ □ Intestinal pain or cramping
□ □ Burning anus
□ □ Rectal pain
□ □ Fatigue after eating
□ □ Hemorrhoids
□ □ Nausea
□ □ Vomiting
□ □ Acid regurgitation / Heart burn
□ □ Bad breath
□ □ Frequent hiccups
□ □ Gallbladder disease
□ □ Liver disease
□ □ Incomplete bowel movement

Skin and Hair

□ □ Rashes
□ □ Eczema
□ □ Dandruff
□ □ Hair loss
□ □ Change in hair / skin texture
□ □ Hives
□ □ Psoriasis
□ □ Itching
□ □ Fungal infections
□ □ Ulcerations
□ □ Acne

Neuropsychological

□ □ Seizures
□ □ Poor Memory
□ □ Irritability
□ □ Stroke
□ □ Mental tension
□ □ Considered or attempted suicide
When: ____________________
□ □ Numbness
□ □ Depression
□ □ Easily stressed
□ □ Mood swings
□ □ Anger easily
□ □ Tics
□ □ Anxiety
□ □ Abuse survivor
□ □ Mental fogginess
□ □ Loss of balance
□ □ Paralysis

Genito-Urinary

□ □ Pain when urinating
□ □ Blood in urine
□ □ Venereal disease
□ □ Incontinence
□ □ Frequent urination
□ □ Bed wetting
□ □ Unable to hold urine
□ □ Urgency to urinate
□ □ Wake to urinate
□ □ Incomplete urination
□ □ Kidney stone
□ □ Difficulty urinating

Urinary output equal to liquid intake? □ Yes □ No

Musculoskeletal pain Please fill out the Pain Management Intake

Your diet

Appetite: □ Low □ Strong □ Too busy to notice

C / P
□ □ Coffee (#/day) __________
□ □ Soft drinks (#/day) __________
□ □ Water (#/day) ___________
□ □ Frequent thirst

C / P
□ □ Artificial sweeteners
□ □ Red meat
How frequently: ____________________
□ □ Decreased thirst

C / P
□ □ Energy Drinks
□ □ Dairy
How frequently: ____________________

Yesterday's breakfast: ____ Lunch: ______________________________________
Dinner: ____ Snacks: ____________________________ Is this a typical day? □ Yes □ No

Your lifestyle

□ □ Alcohol
How often? ________________

□ □ Marijuana
How often? ______________________

□ □ Tobacco
How much? _______________________

□ □ Other recreational drug use
□ □ Exercise Type: ____ Frequency: ________________________
□ □ Stress Cause: ____

Your sleep

□ □ Difficulty falling asleep
□ □ Vivid dreams
□ □ Frequent waking
What time: ________________________
For how long: ______________________

□ □ Difficulty staying asleep
□ □ Good sleep quality

□ □ Wake feeling rested
□ □ Poor sleep quality

Birth Mother's Prenatal history

Was your child adopted? □ Yes □ No Age of child at time of adoption: ______________________

If yes and you know the pregnancy and birth history, please continue filling out the intake. If you don't know the pregnancy and birth history, please fill out anything else that applies to your child.

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
□ Depression/Anxiety □ Thyroid problems □ Illnesses □ Gestational Diabetes
Consumption of: □ Cigarettes □ Alcohol □ Drugs
Surgery: _______________________________________ Medications: ____
Other: ____

Child's Birth History

Term: □ Premature Weeks: _______ □ Full Weeks: _________ □ Late Weeks: ______
Length of labor: _______________________ Any complications? ____
Delivery: □ Vaginal □ C-Section □ Induced □ Forceps □ Suction □ Anesthesia used What type: ______________________________
At birth: Weight ________ lbs _______ oz, Height: ________ inches
Did your child have any of the following problems shortly after birth? □ Blue baby □ Cerebral Palsy □ Seizures □ Jaundice □ Colic
□ Fever □ Rashes □ Other birth abnormality: ________________________________ □ Other birth injury: __________________
Other: ____

Feeding and Development

Breastfed? □ Yes □ No If yes, how long? ____________________________ Reason discontinued? _______________________________
Formula? □ Yes □ No If yes, □ Cow's milk □ Soy □ Other ____
Age began solids: ________ Which foods? ____
Age began: Sitting __________ Crawling: ____________ Walking: ______________ Talking: ____________
Age your child: Cut their first tooth: _____________________________ Lost their first tooth:_____________________________
Any deviations off the standard expected growth chart for height and/or weight? □ Yes □ No
If yes, please describe: ____
How would you describe your child's temperament? ____

Is there anything else about your child or their health history you feel we should know about? __________________________________
____
____