Intake Form: Children under 12 Heavenly Star Acupuncture

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| Name: | | Date of birth: |
| Gender: | | Siblings: |
| Parent: | | Telephone: |
| Address: | | |
| Email: | | |
| **Chief complaint (describe it in detail)** |  | |
| Since when? |
| Any treatment/therapy or medicine?  Any progress?  Anything which relieves or worsens the situation? |
| Has it happened before? |
| Is it family related? |
| **Past history of diseases, operations and medicine use** |  | |
| Any family diseases? |  | |

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| --- | --- |
| Results of examinations by western medicine doctors? |  |
| **General information** | |
| How well does your child sleep (dreams/ nightmare), duration of sleep etc.? |  |
| Diet /appetite  Restrictions, intolerances |  |
| Digestion |  |
| Urine – what colour, how frequent, up in the night to urinate?  Defecation – how often, what colour, what consistency, any strong odours, any undigested food? |  |
| Sweating (day/night) |  |
| Aversion to cold / hot |  |
| Headache (location) |  |
| Dizziness |  |
| Nausea / vomiting |  |
| Joints/muscular pain |  |
| Accident/trauma |  |
| Tiredness |  |
| Emotional situation |  |
| Eyes: dry, itchy, poor sight, discharge, glasses etc. |  |
| Ears: Tinnitus, deafness etc. |  |
| Nose: Blocked, runny, notice any particular smells etc. |  |
| Allergies? |  |
| Motor skills? |  |
| Complexion (pale / red) |  |
| Heart beat rate (fast, slow, irregular?) |  |
| Other information if any (hair loss, nails, skin etc.) |  |
| Other concerns which you think might be important in treating your child |  |