Intake Form: Children under 12 Heavenly Star Acupuncture

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?	

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 heavenly star acupuncture