

# Acupuncture & Integrative Medicine Center

3201 N. 3<sup>rd</sup> Street – Phoenix, Arizona 85012

Phone: (602) 265-1774 Fax: (602) 265-1738

## INTAKE FORM - PEDIATRIC

### PATIENT INFORMATION

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street Apt. #

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_

Gender: M / F

### GUARDIAN OR PARENT INFORMATION

Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
(if different from patient information) Street Apt. #

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status:  single  partnered  married  divorced  widowed  separated

Social Security #: \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_  
(Or how did you hear about us?)

### EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alt. Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alt. Number: \_\_\_\_\_

Name of Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_



**CURRENT MEDICATIONS, VITAMINS, & OTHER SUPPLEMENTS: (Please include dosages)**

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**HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES: (Please include dates)**

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**ALLERGIES (drugs, food, or other substances):**

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**PRENATAL/BIRTH/FEEDING HISTORY**

Please list any health problems *mother* experienced during pregnancy with this child: \_\_\_\_\_

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Term of pregnancy (circle one): Full    Premature    Late                      Birth Weight: \_\_\_\_\_

Any complications with delivery (circle one)? No Yes; \_\_\_\_\_

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Place of Birth (circle one): Hospital    Home    Clinic    Other: \_\_\_\_\_

Feeding (Please  applicable):

Breast Fed:  No     Yes; How long? \_\_\_\_\_

Formula:  No     Yes; What type(s): \_\_\_\_\_ How long? \_\_\_\_\_

Age solid foods began: \_\_\_\_\_ What foods: \_\_\_\_\_

Food Intolerances:  No     Yes; (list foods) \_\_\_\_\_

Favorite foods: \_\_\_\_\_

24-hour Food/Drink Intake (please list yesterday): \_\_\_\_\_

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**SOCIAL HISTORY**

Are parents (circle one): Married / Separated / Divorced / Other: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_; Full-time / Part-time

Father's occupation: \_\_\_\_\_; Full-time / Part-time

Guardian: \_\_\_\_\_; Relationship: \_\_\_\_\_

Other's residing in home?  No  Yes; \_\_\_\_\_ Relationship: \_\_\_\_\_

Daycare?  No  Yes; Where: \_\_\_\_\_

Siblings?  No  Yes; (please list names, ages, and any health problems below:

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

**FAMILY HISTORY**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV+              | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Psoriasis        |
| <input type="checkbox"/> Alcoholism             | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Senility         |
| <input type="checkbox"/> Allergies/hay fever    | <input type="checkbox"/> Gout                | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Skin problems    |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Breast cancer          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Suicide          |
| <input type="checkbox"/> Cervical cancer        | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Ovarian cancer         | <input type="checkbox"/> Loss of height      | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Prostate cancer        | <input type="checkbox"/> Mental illness      | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> Uterine cancer         | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Other cancer:<br>_____ | <input type="checkbox"/> Obesity             |   |
|   | <input type="checkbox"/> Osteoporosis        |   |

**OTHER INFORMATION**

Is there anything else you would like the doctor to know about you/your child?

\_\_\_\_\_  
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