OPEN CIRCLE
ACUPUNCTURE & HEALING

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PEDIATRIC HEALTH HISTORY

Name: ..... Date: .....

Address:.....City:..... State: ..... Zip: .....

Email: .....

Primary Phone: ..... Date of Birth: .....

Emergency Contact & Phone: .....

Pediatrician & other current healthcare providers? .....

NOTICE OF RECEIPT OF PRIVACY POLICIES

As mandated by federal and state legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information.

I have received, read, and understood Open Circle Acupuncture's Privacy Policy Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

By signing below you acknowledge that you have received and read a copy of our privacy policies information.

(This is included on this clipboard, under the health history forms, for you to read, or you may request a copy to read at the clinic if you downloaded paperwork online.)

Signature:_____

Patient or guardian

Primary Concerns				
Please list your top two concerns in order of importance to you.	Mark an X on the scale to indicate the severity of the condition.	When did this start?	What makes it better?	What makes it worse?
1.	1 — 10			
2.	1 — 10			

What are your main goals for your child's acupuncture treatments?

Injuries & Surgeries (including dental) — Please list what happened to what body area and when it occurred.

Date	*Issue*
.....	.....
.....	.....
.....	.....

Medications — Please list any medications, herbs or supplements that your child takes regularly**.**

What taken	*For what condition*
.....	.....
.....	.....
.....	.....

Mom's Birth History (check all that apply or fill in response)				
❑ Hospital birth	❑ Home birth	❑ Vaginal delivery	❑ Cesarean Section	❑ Breech delivery
❑ Complications during birth	❑ Jaundice	❑ Respiratory Distress	# of children	# of pregnancies

Childhood Illnesses (check all that apply to your child)				
❑ Allergies	❑ Anemia	❑ Developmental Delays	❑ Asthma	❑ Anxiety
❑ Bed Wetting	❑ Behavioral Problems	❑ Broken Bones	❑ Chronic Earaches	❑ Colds/Flu
❑ Colic	❑ Convulsions /Seizures	❑ Delayed Speech	❑ Type 1 Diabetes	❑ Digestive Issues
❑ ADD/ADHD	❑ Reflux	❑ Hearing Issues/Deafness	❑ Cancer	❑ Hyperactivity
❑ Neck Pain/Torticollis	❑ Heart Issues	❑ Orthopedic Problems	❑ Paralysis	❑ Painful Urination/UTI

TEMPERATURE — How warm or cold does your child feel relative to other people (e.g., do they usually need to wear more layers or fewer)?

COLD —— HOT

ENERGY: How much energy does your child have in comparison with those around him/her?

LOW —— HIGH

Mark an X on the scales and check any boxes of symptoms or conditions your child has had **in the past 6 months**

DIGESTION

- ❑ Indigestion
- ❑ Gas
- ❑ Bloating
- ❑ Belching
- ❑ Poor appetite
- ❑ Nausea
- ❑ Obesity
- ❑ Vomiting
- ❑ Bad breath
- ❑ Heartburn
- ❑ Hernia
- ❑ Food intolerances or allergies
- ❑ Excess hunger
- ❑ Picky eater

DIARRHEA ——————————————— CONSTIPATION

BM: How often?

..... *x every*
..... *days*

Stools keep shape?

❑ Yes ❑ No

- ❑ Alternating diarrhea & constipation / IBS
- ❑ Dry stools
- ❑ Difficult to pass
- ❑ Tired After BM
- ❑ Pain with BM
- ❑ Foul-smelling stools

SLEEP

.....# hours per night

- ❑ Difficulty falling asleep
- ❑ Nightmares/Night terrors
- ❑ Restless sleep
- ❑ Bedwetting
- ❑ Not rested upon waking
- ❑ Sleep walking
- ❑ Wake ..... *x per night at ..... am / pm*
- ❑ Wake to urinate: *how often: :.....*

Emotions — What emotions does your child experience on a regular basis?

- ❑ Anger
- ❑ Irritability
- ❑ Anxiety
- ❑ Worry
- ❑ Obsessive Thinking
- ❑ Sadness
- ❑ Grief
- ❑ Depression
- ❑ Joy
- ❑ Fear
- ❑ Timid / Shy
- ❑ Indecisiveness

RESPIRATORY

- ❑ Allergies
- ❑ Frequent Colds/Flus
- ❑ Tight sensation in chest
- ❑ Production of Phlegm. Color?.....
- ❑ Sinus Issues
- ❑ Bronchitis/Pneumonia
- ❑ Cough

SKIN & HAIR

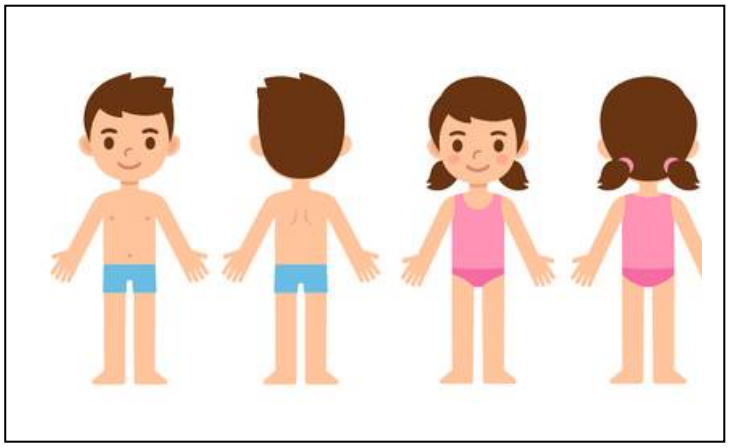
- ❑ Dry Skin
- ❑ Rashes
- ❑ Face Flushing
- ❑ Eczema
- ❑ Psoriasis
- ❑ Itching
- ❑ Hair Loss

CARDIOVASCULAR

- ❑ Heart Murmur
- ❑ Bruises Easily
- ❑ Chest Pain/Pressure
- ❑ High Blood Pressure
- ❑ Fainting
- ❑ Diagnosed HT problem
- ❑ Cold Hands/Feet
- ❑ Low Blood Pressure
- ❑ Palpitations
- ❑ Spontaneous Sweating

NEUROLOGICAL

- ❑ Loss of Sensation
- ❑ Slow or Slurred Speech
- ❑ Lack of Coordination
- ❑ Numbness
- ❑ Tremors
- ❑ Loss of Balance
- ❑ Seizures
- ❑ Concussion
- ❑ Dizziness
- ❑ Headaches
- ❑ Migraine



Place an X on any areas of the body to show locations of pain, tightness or discomfort

Patient Informed Consent

I agree to receive acupuncture treatment by the licensed acupuncturists of Open Circle Acupuncture & Healing. I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. On rare occasions, current symptoms may worsen before they find relief. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

I understand that the acupuncturists of Open Circle Acupuncture & Healing use only sterile, disposable, single-use needles, practice safe needling techniques, and maintain a clean and safe environment. I understand that other modalities may be used including cupping therapy, acupressure balls, press needles, magnets and laser therapy.

I understand that the Open Circle Acupuncture & Healing practice may reach out to medical providers to introduce our services. No confidential information will be released. I understand that the clinical and medical staff may review my files, but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

I have read this form and have also had an opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree:

....

Signature (Parent or Guardian) Date

Cancelation Policy

I understand that Open Circle Acupuncture will charge the full session fee or one treatment off of a package when a session is broken either by not providing 24 hours' notice of cancellation, not showing, or showing up 15 minutes after my appointment time. Packages already in use are non-refundable but can be shared, gifted or donated.

…… ……..

Signature (Parent or Guardian) Date

How Did You Hear About Us?

- ❑ Friend or Family:……. (we want to thank them!)
- ❑ Health Practitioner:……. (we want to thank them!)
- ❑ Picked up Postcard, Coupon or Misc Print Material
- ❑ Drove by or Live in the Neighborhood
- ❑ Google or Internet Search
- ❑ Yelp
- ❑ Facebook/Twitter/Instagram
- ❑ Other……