Sue Foss
East Asian Medicine Practitioner

Personal Details

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name(s): _____ Preferred Phone: _____

Mailing Address: _____
Street City State Zip

Child's Primary Care Provider: _____ Phone: _____

Please list reason for your appointment today from most to least important.

_____

_____

Pregnancy and Birth

Place of Birth: _____

Child is yours by: (Check one) ☐Birth ☐Adoption ☐Step Child ☐Other _____

Please note any medical problems associated with pregnancy, including fertility Issues.

_____

_____

Describe any interventions at birth including cesarean section.

_____

Gestational age at birth: _____ Birth Weight: _____ Birth Length: _____

Location of Birth: ☐Home ☐Hospital ☐Birthing Center

Health issues during newborn period _____

Child breast fed: ☐Yes / ☐No If yes, how long?

When was solid food introduced? _____

Food or feeding problems: _____

Vaccination History

MMR: ☐Yes / ☐No Age: _____ DPT: ☐Yes / ☐No Age: _____ Hib: ☐Yes / ☐No Age: _____ Hep B: ☐Yes / ☐No Age: _____

Chicken Pox: ☐Yes / ☐No Age:_____ Polio: ☐Yes / ☐No Age:_____ Others: _____

Please note any adverse reactions to vaccines: _____

Social History

Are both parents living in the home? ☐Yes / ☐No

Names and ages of siblings, if any: _____

Pets: _____

Recent travel: _____

Recent life changes: _____

Does your child attend school? ☐Yes / ☐No. If yes, what grade?

Any concerns about school?_____

Sports, activities: _____

Please list any concerns you have about your child's social interactions. _____

_____

Medical History

Past and current medications: _____

Supplements: _____

Illnesses: _____

Surgeries or other trauma: _____

_____

_____

Medical History

Please describe your typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Beverages: _____

Please check any of the conditions listed below that are a concern for your child:

Appetite: ☐ poor / ☐ excessive
Energy level: ☐ low / ☐ excessive
Thirst: ☐ little / ☐ excessive
Energy level: ☐ low / ☐ excessive
Sleep: ☐ poor / ☐ excessive sleepiness / ☐ night terrors
Bowel movements: ☐ constipation / ☐ loose stools / ☐ diarrhea
Urination: ☐ frequent / ☐ painful / ☐ bedwetting

☐ Poor concentration
☐ Frequent colds
☐ Headaches
☐ Unusual sweating
☐ Asthma
☐ Seizures

Skin problems: Specify: _____

Allergies: _____

Emotional problems: _____

Other: _____

Family Health History

Please note which family member has any of the following:

Condition	Family Member	Condition	Family Member
☐ Heart Disease		☐ Asthma	
☐ Cancer		☐ Congenital Disorders	
☐ Thyroid Disorder		☐ Seizures	
☐ Hepatitis		☐ Mental Illness	
☐ Allergies		☐ Neurological Disorders	
☐ Auto-Immune Disease		Other (please specify)	

All health and medical information represented here is true and correct to the best of my knowledge.

Signature of legal guardian _____ *Date* _____