Patient Health History
For Children under 12 years of age

Patient's Name:_____Date:_____
Parent's Name:_____
Address:_____
City, State, Zip code _____
Home Phone:_____
Work Phone:_____Cell Phone:_____
Email address:_____
Child's Date of Birth:_____ Child's Age:_____
Emergency contact:_____
Primary Physician:_____
Referred by:_____
Current Medications:_____
_____

Treatment Goal(s)
What is the main condition you would like to address?
_____
_____
_____
How does this affect his/her daily activities (school, sleeping, etc)?
Describe any school reports, teacher comments, demerits, detentions, daily/weekly reports, etc: _____
_____
_____
_____
_____
_____
_____
_____

When did this condition begin?_____

What diagnosis, if any, have you been given?_____
What treatments have you tried?_____
_____
Other conditions you would like to address_____
_____

Past Medical History

Check all that apply and indicate dates where applicable

___ Allergies	___ Hepatitis	___ Seizures
___ Cancer	___ HIV	___ Stroke
___ Diabetes	___ Heart Disease	___ Surgery
___ Epilepsy	___ IBS/Crohn's, etc	___Thyroid Disease

Other significant medical condition:_____
Trauma/Accidents_____

Diet/Nutrition

How much soda does she/he drink per day?_____
How much water does she/he drink per day?_____
How often does she/he eat the following;

Vegetables_____	Candy_____	Milk_____
Fruit _____	Chips _____	Ice cream_____
Red meat _____	Fast food _____	Juice_____

Refined carbs (bread, pastries, cake, cookies, etc)_____
What supplements does she/he currently take?_____
_____
_____

Current Health Indicators

Height_____ Weight _____
Recent change in weight?_____

Body Temperature

___ Cold fingers	___ Feel hot all over	___ Thirsty
___ Cold hands	___ Feel hot in afternoon	___ Thirsty at night
___ Cold arms	___ Hot flashes	___ Sweaty at night
___ Cold toes	___ Feel hot in hands	___ Sweat easily
___ Cold feet	___ Feel hot in feet	___ Lack of sweat
___ Cold legs	___ Feel hot in face	__Wakes up thirsty
___ Feel cold all over	___ Feel feverish	

Energy Level

___ Low energy Low energy at specific time of day:_____

___ Shortness of breath ___ Sleepy during day ___ Lethargic

___ Reluctance to talk ___ Lazy/inactive ___ Loud/talkative

___ Soft spoken/quiet ___ Frequently tired ___ Energetic

Sleep Patterns

___ Insomnia ___ Wakes often during night. If so, what time?_____

___ Restless sleep ___ Fitful sleep

___ Hard to fall asleep ___Wakes with nightmares

___ Wets the bed ___Wakes to urinate

___Walk/talk while asleep ___ Wakes too early (4-5am)

Concentration/Memory

___ Poor concentration ___ Doesn't follow directions well

___ Easily confused ___ Absent minded

___ Short attention span ___ Unclear speech, stutter ___ Poor grades

___ Mental fatigue ___ Forgetful ___ Unclear thinking

___ Stares off into space ___ Slow learner ___Difficulty memorizing

Is it worse when tired/hungry/at a certain time of day?_____

Mood/Behavior

___ Anxious ___Aggressive ___ Hits others

___Sad, depressed ___ Pensive ___ Mood swings

___ Easily frightened ___ Phobias ___ Irritable

___ Easily startled ___ Easily frustrated ___ Easily angry

___ Timid ___ Fidgety ___ Starts fights

___ Apprehensive ___ Restless ___ Outbursts

___ Worries ___ Frequent sighing ___ Short temper

___ Fearful ___ Moody

___ Has difficulty with change in plans or routine

___Easily unsettled by trivial things

Other:_____

Is the behavior worse when tired/hungry/after eating sweets

Is the behavior worse at a certain time of day?_____

Lung and Associated TCM Functions

___ Nasal Discharge: Color_____Thick or Thin

___ Cough ___ Dry mouth ___ Dry skin

___ Nose bleeds ___ Dry throat ___ Snorting

___ Sinus congestion ___ Dry nose ___ Sneezing
___ Overall achy body ___ Stiff neck ___ Stiff shoulders
___ Sore throat ___ Difficulty breathing ___Feel sad
___ Allergies ___ Clears throat frequently ___ Melancholy
___ Headaches. If so, where & how often_____

Spleen and Associated TCM Functions

___ Low appetite ___ Abdominal gas ___ Hemorrhoids
___ Crave sweets ___ Gurgling stomach ___ Bruise easily
___ Abdominal bloating ___ Feel tired after eating ___ Weight loss
___ Loose stools ___ Urgent BMs ___ Weight gain
___ Discomfort after BM ___ Constipation ___ Dizzy
___ Diarrhea ___ Mucous/Blood/undigested food in stool
Number of bowel movements per day (or per week)_____

Stomach and Associated TCM Functions

___ Heartburn ___ Mouth sores (canker sores/cold sores)
___ Pain after eating ___ Bleeding, painful or swollen gums
___ Large appetite ___ Nausea ___ Vomiting
___ Bad breath ___ Acne ___Acid regurgitation
___ Belching ___ Hiccups ___ Stomach pain

Liver/Gallbladder and Associated TCM Functions

___ Alternating diarrhea and constipation ___ High stress level
___ Bitter taste in mouth ___ Bad temper ___Headaches
___ Anger easily ___ Irritable ___Heat in head/face
___ Frustration ___ Lump in throat ___ Muscle twitches
___ Depression ___ Feel tense ___Gall stones
___ Itchy/dry skin/rashes ___Discomfort/tightness/tension around ribcage

Eyes:

___ Itchy ___ Bloodshot ___ Dry
___ Watery ___ Blurred vision ___ Poor vision
___ Poor vision at night ___ Eyes feel hot ___ Floaters

Kidney and Associated TCM Functions

___ Low back pain/weakness ___ Weak or sore knees
___ Kidney stones ___ Kidney infections
___ Bladder/Kidney/urinary infection ___ Lack of bladder control
___ Frequent broken bones ___ Frequent cavities

Urination:

___ Normal color ___ Reddish ___ With blood
___ Dark yellow. If yes, do you take vitamins?_____
___ Clear ___ Cloudy ___Scanty
___ Profuse ___ Frequent ___ Strong odor
___ Painful ___ Dribbling ___ Urgent
___ Difficult Other_____

If the patient is experiencing pain, please complete the following;
Quality of pain: __ sharp __ stabbing __ throbbing __dull
__ burning __cramping other_____
__ continuous ___ comes & goes
__ numbness __ wakes you up at night
Do any of the following lessen the pain? ___heat ___ cold
___ holding the area (pressure) ___ rest ___ stretching
___ gentle movement ___ vigorous exercise
Do any of the following worsen the pain? ___ heat ___ cold
___ pressure ___ rest (worse during sleep) ___ movement
___ weather if so, explain_____

Any other comments: _____
_____
_____
_____
_____
_____

_____ _____
Parent's signature Date

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