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Pediatric Patient Information Sheet

CONFIDENTIAL

Living Water Acupuncture 6601 W. Deschutes Ave Ste. D Kennewick, Wa. 99336.

(509) 460-1286

www.LivingWaterAcupuncture.com

Date	Child's Full Name	Preferred Name/Nickname	
Gender M F	Date of Birth	Age	Guardian's Full Name & Relationship
Address	City	State	Zip
Phone # during business hours (home, work, cell – circle one)	Alternate Phone # (home, work, cell – circle one)		
Cancellation Policy – I acknowledge that I will give at least 24 hour notice of cancellation to avoid a $35 charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials _____			

MAJOR COMPLAINT(S), in order of importance to your child:

Severe Moderate Slight

1. ❑ ❑ ❑

_____

_____

2. ❑ ❑ ❑

_____
_____

3. ❑ ❑ ❑

_____
_____

Current medications and their doses:_____
_____
_____
_____
_____
_____

Supplements/Herbs/HomeRemedies:_____
_____
_____
_____

Allergies/Reactions to Medicines or Vaccinations:_____
_____

Other Known Allergies:_____
_____

PREGNANCY

List any medications/drugs taken during pregnancy (include over-the-counter medications):_____
_____

Any alcohol? ❑ No ❑ Yes How much? _____ Any tobacco? ❑ No ❑ Yes How much?_____

High blood pressure? ❑ No ❑ Yes

Illnesses/Infections during pregnancy? ❑ No ❑ Yes_____

Please indicate any medical problems during pregnancy ❑ None ❑

Specify:_____
_____

LABOR & DELIVERY

Is the child yours by: ❑ Birth ❑ Adoption ❑ Stepchild ❑

Other:_____

Delivery by ❑ Vaginal birth ❑ Caesarean If Caesarean, why?_____

Breech or unusual presentation? Yes ❑ No ❑
_____

Pain medication used?❑ No ❑ Yes

Pitocin used? ❑ No ❑ Yes Forceps used? ❑ No ❑ Yes

Delay in respiration or cry? ❑ No ❑ Yes

Was oxygen administration necessary? ❑ No ❑ Yes

Birth weight (lbs): _____ Birth length (in.): _____ If premature, how early?
_____

Please indicate any medical problems during the baby's birth. ❑ None

_____
_____
_____
_____

NEWBORN

Jaundice ❑ No ❑ Yes
Infection ❑ No ❑ Yes
Seizures ❑ No ❑ Yes
Anemia ❑ No ❑ Yes
Home from hospital in _____ days.
Please indicate any medical problems during the newborn period. ❑ None

_____
_____
_____
_____

NUTRITION & FEEDING

Is your child breastfed? ❑ No ❑ Yes If so, how long?_____
Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify:_____
_____

INFECTIOUS DISEASES

Has your child had: ❑ Chickenpox ❑ Measles ❑ Mumps ❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB) ❑
Other_____
_____

IMMUNIZATIONS

Is your child following the childhood vaccination schedule as recommended by your child's pediatrician? ❑ No ❑ Yes
Any complications from vaccinations? ❑ No ❑ Yes

EXPOSURES

Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes
Do any household members smoke? ❑ No ❑ Yes

ILLNESSES

Hospitalizations:
Age _____
Reason_____
Age _____
Reason_____
Age _____
Reason_____

Any history of head injury? ❑ No ❑ Yes
_____

Has this child ever been unconscious? ❑ No ❑ Yes

_____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

_____

_____

_____

ANY ADDITIONAL INFORMATION:

_____

_____

_____

Previous complications of any therapy?_____

_____

Signed Relationship to child

_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Patient's Name _____

Patient's Signature_____ Date Signed _____

To be completed by the patient's representative if the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____
Print Name of Patient Representative _____
Signature of Patient Representative _____
Relationship or Authority of Patient _____
Name of Acupuncturist: Cedar S. Kennedy, MAcOM, L.Ac.

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