Arbor Vitae Acupuncture, P.C.
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PEDIATRIC PATIENT QUESTIONNAIRE

Child's Name_____ Sex: M/F

Parents' (Legal Guardians') Names: _____

Month, Date, Year and Time of Birth: _____

Location of Birth (City, Town, Country):_____

Siblings and Ages: _____

Pediatrician's Name, Phone No., Address: _____

Does your child currently take medications? (Please list type and frequency):

Prescription: _____

Non-prescription:_____

Previous medical treatments, diagnostic tests, surgeries (please indicate dates):
_____

_____

On a separate piece of paper please answer the following questions in detail:

1. Please describe your child's condition in your own words. Include any relevant history and medical or diagnostic opinions concerning the condition.
2. Has your child ever been treated with alternative medical modalities before? What modality (acupuncture, homeopathy, massage, etc.), and for what condition?
3. Briefly describe the pregnancy, labor, and post-partum.
4. Briefly describe any character traits, behavior issues, parenting factors, or spiritual distress which you feel impacts your child's case.
5. Briefly describe your child's day (day care or school, extra-curricular activities).
6. Describe your child's diet. Include allergies, cravings and aversions. If nursing, describe your own diet and frequency and times of day of the nursing sessions.