Karen Craven Acupuncture

Pediatric Patient Intake Form

Thank you for coming. Please help us provide your child with a thorough evaluation by taking the time to carefully fill out this questionnaire. All your information will be confidential. If you have questions, please ask.

Date		
Patient name		
Date of birth	Age	Sex F M

Parent/Gaurdian name(s)		
Address		
Street		
City	State	Zip Code
E-mail Address:		
Please check preferred contact method		
☐ Home phone #		
☐ Cell phone #		
☐ Work phone #		
How did you hear about us?		
Referred By:		
Other:		

Reason for visit

Pregnancy and Birth

Place of birth:		
Child is yours by: (circle one) birth/adoption/stepchild/other		
Please note any medical problems associated with pregnancy, including fertility issues.		
Describe any interventions at birth including caesarean section.		
Was skin to skin contact allowed immediately after birth? Y N		
Gestational age at birth:	Birth weight:	Birth length:
Location of birth: (circle one) home / hospital / birthing center		
Health issues during newborn period:		
Where did child sleep for first 3 months of life?		
Where does child sleep now?		
Child breastfed? Y N	If yes, how long?	
When was solid food introduced?		
Food or feeding problems:		

Vaccination History

MMR Y N Age:	DPT Y N Age:	Hib Y N Age:
Hep B Y N Age:	Chicken Pox Y N Age:	Polio Y N Age:
Others:		
Please note any adverse reactions to vaccines:		

Social History

Are both parents living in the home? Y N
Names and ages of siblings, if any:
Pets:
Recent travel:
Recent life changes:
Does your child attend school? Y N If yes, what grade?
Any concerns about school?
Sports, activities:
Please list any concern you have about your child's social interactions:

Typical Diet

Breakfast:
Lunch:
Dinner:
Snacks:
Beverages:

Past medical history (Please include the month/year when the diagnosis was established)

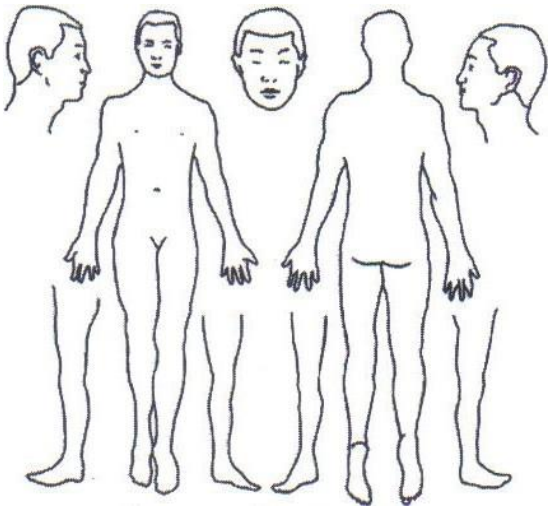
Significant illness:			
Surgeries:			
Hospitalization:			
Significant trauma:			

Family medical history (Please specify family member)

Significant illness	Family member(s)
☐ Alcoholism	
☐ Allergies	
☐ Asthma	
☐ Autoimmune Disease	
☐ Cancer	
☐ Congenital Disorders	
☐ Diabetes	
☐ Heart disease	
☐ Hypertension	
☐ Mental Illness	
☐ Miscarriage	
☐ Stroke	
☐ Other (please specify)	

Recent medical history

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

☐ Poor appetite	☐ Poor sleeping	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Cravings	☐ Change in appetite
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain
☐ Peculiar tastes	☐ Desire hot food	☐ Desire cold food	☐ Strong thirst (cold or hot drinks)	
☐ Sudden energy drop (What time of day?)				
Favorite time of year?		Worst time of year?		

Skin and hair

☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Dandruff	☐ Dry skin	☐ Recent moles	☐ Loss of hair
☐ Purpura	☐ Change in hair or skin textures		Other?	

Musculoskeletal

☐ Joint disorders	☐ Weakness in muscles	☐ Pain/soreness in muscles		☐ Tremors
☐ Difficulty walking	☐ Cold hands/feet	☐ Swelling of hands/feet		☐ Back pain
☐ Spinal curvature	☐ Hernia	☐ Numbness	☐ Tingling	☐ Paralysis
☐ Neck tightness	☐ Neck pain	☐ Shoulder pain	☐ Hand/wrist pain	☐ Hip pain
☐ Knee pain	☐ Joint sprain	☐ Other?		

Head, eyes, ears, nose, and throat

☐ Dizziness	☐ Concussions	☐ Migraines	☐ Glasses/lens	☐ Eye strain
☐ Eye pain	☐ Color blindness	☐ Night blindness	☐ Poor vision	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing	
☐ Spots in front of eyes	☐ Sinus problems	☐ Nose bleeding	☐ Sore throat	☐ Grinding teeth
☐ Teeth problems	☐ Facial pain	☐ Jaw clicks	☐ Sores on lips/tongue	
☐ Difficulty swallowing		☐ Other?		

Recent medical history (continued)

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

Respiratory

☐ Cough	☐ Coughing blood	☐ Wheezing	☐ Difficulty breathing	☐ Bronchitis
☐ Pneumonia	☐ Chest pain	☐ Production of phlegm – what color?		

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Gas
☐ Belching	☐ Black stools	☐ Blood in stools	☐ Indigestion	☐ Bad breath
☐ Rectal pain	☐ Hemorrhoids	☐ Abdominal pain/cramps		
☐ Gallbladder problems		☐ Parasites	☐ Chronic laxative use	
Bowel movements:	Frequency _____	Color _____	Odor _____	Texture/form _____

Neuropsychological

☐ Loss of balance	☐ Lack of coordination	☐ Concussion	☐ Depression	☐ Anxiety
☐ Stress	☐ Bad temper	☐ Bi-polar		

Genitourinary

☐ Pain on urination	☐ Frequent urination	☐ Blood in urine	☐ Urgent to urinate	☐ Kidney stones
☐ Unable to hold urine	☐ Dribbling	☐ Pause of flow	☐ Frequent urinary tract infection	
☐ Genital pain	☐ Genital itching	☐ Other?		

Recent medical history (continued)

Allergies / Sensitivities: ☐ Yes ☐ No (if No, skip this section)

☐ Food	☐ Environmental	☐ Chemicals	☐ Other

Have you had: ☐ Skin prick test ☐ Allergy blood test? When? _____

What symptoms do you experience?

☐ Itching	☐ Hives	☐ Rashes	☐ Sinus congestion
☐ Post nasal drip	☐ Swelling	☐ Yawning attacks	☐ Episodes of diminished hearing
☐ Digestive issues	☐ Joint pain	☐ Asthma attacks	☐ Mental fog
☐ Mood swings	☐ Other?		

Does anyone else in your family experience these issues? ☐ Yes ☐ No

Have you ever been hospitalized for an allergy attack? ☐ Yes ☐ No

Do you carry an epi pen? ☐ Yes ☐ No

Have you received allergy shots? ☐ Yes ☐ No

Please list medications taken within the last two months (including vitamins, OTC drugs, herbs, etc.)

Medication	Dosage	Frequency	Reason for taking

In consideration for our allergy patients, we ask everyone visiting our clinic to follow these rules of cooperation:

- **Do not bring outside food or drink other than water into the clinic**
- **Do not bring animals into the clinic**
- **Avoid wearing scented fragrances to the clinic**

If you need to cancel or reschedule an appointment, we would appreciate at least 24 hours' notice. We charge a fee of $40 for missed appointments or appointments cancelled with less than 24 hours' notice.

I understand the above information and confirm this form was completed correctly to the best of my knowledge.

Signature: _____ ☐Adult patient ☐Parent or Guardian ☐Spouse

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated 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 the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), traditional herbal medicine and nutritional counseling. I understand that most herbs will be in capsule form, but others may need to be prepared and consumed as an herbal tea according to the instructions provided orally and in writing. The herbal teas may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Traditional Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient 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, the above 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.

Acupuncturist Name: Karen Craven, MAcOM, Dipl. OM, L.Ac.

(Date)

Patient Signature **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

Karen Craven Acupuncture

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Nashville, TN 37216
Phone: 615-228-3286 Fax: 855-217-9775

Karen Craven L.Ac.

Acknowledgement of Privacy Practices

I consent to the use or disclosure of my identifiable health information by Karen Craven Acupuncture (hereafter noted as KCA) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at KCA may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. KCA is not required to agree to the restrictions that I may request. However, if KCA agrees to a restriction that I request, the restriction is binding upon KCA.

I have the right to revoke this consent, in writing, at any time except to the extent that KCA has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review KCA's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Karen Craven Acupuncture. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at karencravenacupuncture.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and with respect to my identifiable health information.

Karen Craven Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Printed Name | (Indicate relationship if signing for patient)

If you wish to authorize Karen Craven Acupuncture to share your health information with any individual(s), please provide the name(s) below.

_____