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Please come to the office free of scents from cigars, cigarettes, after shave, perfume, cologne, hand cream, shampoo, cream rinse, laundry detergent, or anti-static laundry cloths. Thank you.

Today's Date_____

CHILD'S INFORMATION

Name _____

Date of Birth_____

Occupation of Mother _____

Work Phone _____

Cell _____

Email _____

Occupation of Father _____

Work Phone_____

Cell_____

Email _____
Mailing Address for mail from this office
_____

_____

Name and phone number of an emergency contact person_____

May I thank the person who referred you? Yes____ No____
Mailing info for this person:
_____

_____
Pediatrician's name and phone #_____
If the child has already been treated with alternative medicine, what was done?

_____

PAST MEDICAL HISTORY
Please briefly list the child's past medical conditions and hospitalizations.
_____

_____

_____

FAMILY HEALTH HISTORY
Describe the child's mother's health
briefly_____
Describe the child's father's health
briefly_____
What illnesses are prominent in your family?
_____

Which medications does the child take during any given week?
_____
Which supplements or herbs does the child take?

_____

Was there anything unusual about the child's birth?

_____

Was the birth traumatic for you in some way?

_____

_____

Any stresses in the home recently that might be impacting the child?

_____

_____

CURRENT HEALTH CONDITION
What exactly do you want me to do for your child? (How will we know when I'm successful?)
_____
_____
_____

LIFE STYLE AND NUTRITION: Please answer for the child, or have the child answer:

Do you usually feel hurried during meals? Y___N___
Do you crave (want very much) sugar? Y___N___
Do you crave certain other tastes or foods? Y__N__
If yes, what do you crave?
_____
Are you a vegetarian? Y___N___
If yes, do you eat eggs? Y___N___
Which of the following do you eat regularly?
Energy drinks ____ Sugar _____ Dairy products _____
Fatty food _____ Salty food _____ Cold raw food _____
Do you tend to eat to calm yourself when angry or sad?
_____
Do you exercise regularly? Y___N___
What do you do to exercise?
_____
How many hours do you normally get each night? _____
Is that enough for you? Yes ___ No ____
When you wake up do you remember your dreams? ____Y ____N

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:
__ anxiety
__ panic attacks
__ cold intolerance
__ heat intolerance
__ decreased memory and concentration
__ depression
__ dry skin
__ easy weight gain
__ difficulty losing weight
__ fluid retention
__ irritable bowel syndrome
__ headaches
__ hair loss
__ irritability
__ severe fatigue even if you sleep enough at night
__ unhealthy nails
(The above symptoms may suggest a low level of thyroid hormone)

For menstruating girls:
__ Pre-Menstrual Syndrome (water retention, irritability)
__ irregular menstrual periods
__ painful menstrual periods

(the above symptoms may suggest a need for Evening Primrose Oil and special herbs)

For both boys and girls:
__ jerking or restless legs in bed at night
__ fatigue even after a good night's sleep
__ unexplained feelings of panic
__ low energy
__ muscle cramps in legs, feet, toes, or fingers
__ heart palpitations or "skipped beats"
(the above symptoms may suggest a need for more of the mineral magnesium)

__ "floaters" that look like dust particles floating across your eyes
__ bruise easily
__ slight bleeding when you brush your teeth
__ hemorrhoids or varicose veins
(the above symptoms may suggest a possible need for bioflavonoids, found in fruit and berries)

__ little or no sense of taste
__ little or no sense of smell
__ slow to heal from an injury or surgery
__ acne or other unwanted conditions of the skin
__ little or no appetite
__ on purpose not eating because you feel you are too fat even when others disagree
(the above symptoms may suggest a possible need for the mineral zinc)

FOR THE FOLLOWING SECTIONS, PLEASE USE NUMBERS FROM 1-10 TO INDICATE HOW SERIOUS THE SYMPTOMS ARE FOR YOU. 1 means an occasional problem. 10 means a severe, chronic, intense problem.

__ depression, like feeling under a dark cloud
__ depression mostly when the weather is overcast
__ worry, anxiety
__ obsessive thoughts
__ obsessive behavior
__ needing to do things a certain way every time you do them or you just don't feel right
__ hard to get to sleep
__ hard to stay asleep
__ panic attacks
__ post traumatic stress syndrome
__ suicidal thoughts or plans
__ feel better after exercise
(the above symptoms may suggest a possible need for the amino acid

tryptophan or another form of tryptophan called 5-HTP, either of which creates more serotonin in your nervous system)

__ depression from feeling life is boring, grey, flat, or empty
__ lack of excitement in anything you're doing
__ fatigue, mental or physical
__ easy to put on weight
__ slow to get up in the morning
__ easily chilled. Often colder than others around you
__ need to sleep more than others you know
(the above symptoms may suggest a need for the amino acid tyrosine or the omega-3 fatty acids found in fish oil or flax seed oil, all of which create more dopamine in your nervous system)

__ very emotional
__ you feelings are very easily hurt
__ cry easily when watching a movie or even commercials
__ avoid dealing with painful issues
__ very sensitive to physical pain
__ hard to get over losses
__ crave pleasure, comfort, reward
__ would rather feel numb than feel hurt emotionally
(the above symptoms may suggest a need for vitamin B complex and the amino acid phenylalanine, which increases the level of endorphins in your nervous system)

__ feel driven, overworked, with many deadlines and pressures
__ tend to be easily upset or frustrated
__ sometimes feel weak or shaky
__ easily overwhelmed. Can't seem to get it all done
__ sensitive to bright lights or loud noises
__ smoking, drinking, eating, or certain drugs help you relax
__ you feel especially bad if you skip meals or go for long without eating
__ stiff, uptight, tense
__ have trouble relaxing and loosening up
(the above symptoms may suggest a need for the amino acid GABA and the mineral chromium)

What other symptoms not mentioned above bother you?

_____

_____

What hobbies do you pursue that may involve paint, glue, plastics, lead, or other substances that could cause allergic reactions?

_____

What foods do you insist your parents keep in the house for you at all times?

_____

What other foods do you just love to eat, and have several times a month or more? _____

Informed Consent

Acupuncture is a technique in which sterile, stainless steel, disposable needles are inserted into specific points on the body to cause a desired healing effect via regulating the flow of Chi (vital energy) in the body.. Risks may include feeling weak, nauseated, faint, infection or bruising at the site of the needle insertion, and occasionally a worsening of symptoms. The benefits of acupuncture may include alleviation of pain, improvement in health, reduction in allergies, and improved sleep

With this knowledge, I voluntarily consent to allow my child, if he or she desires it, to have acupuncture treatments.

_____

Signature of parent/guardian Date

If you do not wish your child to have acupuncture treatments, you can choose acupressure, instead, which is the gentle pressure of Carolyn's hands on the skin at the acupuncture sites.

I agree to allow Carolyn to treat my children with acupressure which may or may not include the rubbing of the skin and tapping on the skin with fingers, electric buzzers, tiny metal rakes or plungers or other devices that children find enjoyable and pleasurable at best or simply tolerate.

_____

Signature of parent/guardian Date

Authorization and Release

I certify that the above information is correct to the best of my knowledge. I will not hold any providers or any staff members of *Carolyn Reuben, L.Ac.* responsible for any error or omissions that I may have made in the completion of this form. I hereby authorize *Carolyn Reuben, L.Ac.* to furnish information to my insurance carriers and treating physicians concerning my (or my child's) illness, condition, and treatments.

I also agree to pay for any appointment cancelled or missed for which I didn't give 24 hours notice.

Signature of parent ____

Date___________________