MARIA MITCHELL LAC, MTCM
CHILD/MINOR INTAKE FORM

This is a confidential questionnaire to help determine the best treatment option for your child. Please fill out completely and accurately as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Name _____ Age __ Date of Birth _____ Today's Date _____

Home Address _____

Name of Parent or Guardian? _____ # of Siblings _____

Family Practitioner _____

Reason for Visit? _____ How Long Has This Been? _____

Other Concerns? _____ Current Medication? _____

Other Treatments at This Time? _____

Has Child Had Acupuncture Before? Y __ N __ If Yes, Practitioners Name _____

For What Condition (If Yes) _____

Please indicate if any Problems with the Following

Frequent Colds __	Ear Infections __	Headaches ___	Eye Problems __
Sinus Infections __	Nose Bleeds __	Nasal Discharge __	Flushed Cheeks __
Coughs __	Excessive Thirst __	Sore Throat __	Bladder/Kidney Infection __
Fevers __	Thrush/Vaginitis/Severe	Diaper Rash __	Convulsions __
Muscle Cramps __	Pneumonia __	Blank or Staring Spells __	

Sleep Habits

Sleeps Well __	Sleeps with Parents __	Difficulty Falling Asleep __	
Disturbing Dreams __	Goes to Bed Late __	Night Urination __	Awakens Regularly __

Moods

Emotionally Stable __	Hyperactive __	Moody __	Withdrawn __
Fears/Phobias/ Panic __		Short Attention Span __	
Recent Family Traumas (Divorce, Moving, etc.) __			Irritable __
Severe Emotional Trauma __		Pronounced Mood Changes __	
Abuse __			

Appetite

Good Appetite __ Poor Appetite __ Very Picky Eater __ Will Eat only Sweets __

Specific Preferences and Dislikes

Digestion

Stomach Aches __ Belching __ Excessive Gas __ Bloating __

Bowel Movements

Regular __ Irregular __ Loose __ Constipation __

Diarrhea __ Anal Itching __

Skin

Itching __ Bumpy __ Rashes __ Cradle Cap __

Birth History

Any Complications? _____

Mother's Illness' During Gestation _____

Birth Weight _____ Normal Development? _____

Family Health History

Major Health Problems of Close Family Members _____

Age and Cause of Death of Close Family Members _____

Do Any Family Members Have:

Allergies ___ Asthma ___ Alcohol/Drug Abuse ___

Childhood Diseases

Hospitalization/Surgeries _____

Significant Accidents _____

Broken Bones _____

Scars _____

Allergies _____

Any Adverse Reactions to Vaccinations _____