Pediatric Intake Form

Patient name _____ Date of Birth_____ Age _____

Parent/Guardian name/s _____ Phone number _____

Address _____

Child's primary care provider _____ Phone number _____

Reasons for your 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 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: (circle one) 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? (circle one) Y N If yes, what grade? _____

Any concerns about school? _____

Sports, activities: _____

Please list any concerns you have about your child's social interactions:_____

_____

Medical History

Past and current medications: _____
Supplements: _____
Illnesses: _____
Surgeries or other trauma: _____

Typical diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Please circle any of the conditions listed below that are a concern for your child:

Appetite: poor / excessive
Headaches
Thirst: little / excessive
Poor concentration
Unusual sweating
Frequent colds
Asthma
Energy level: low / excessive
Sleep: poor / excessive sleepiness / night terrors
Bowel movements: constipation / loose stools / diarrhea
Urination: frequent / painful / bedwetting
Seizures

Skin problems: Specify: _____

Allergies: _____

Emotional problems: _____

Other: _____

Family Health History

Please note which family member has any of the following:

Condition	(check)	Family Member
Heart Disease		
Cancer		
Thyroid Disorder		
Allergies		
Autoimmune Disease		
Asthma		
Congenital Disorders		
Seizures		
Mental Illness		
Neurological Disorders		
Other (please specify)		

Minor Consent to Treat

I authorize Sustaining Health Acupuncture, LLC, and any agents representing them, to administer care as deemed necessary to my _____(relationship).

Patient's Name: _____

Parent or Guardian Signature: _____ Date: _____

Payment and Cancellation Policy

Please initial each item and sign below.

_____ I understand that payment is due at time of service.

_____ In order to provide high quality healthcare to all patients, Sustaining Health Acupuncture requires 24 hours advanced notice in order to cancel or reschedule an appointment. In the event that I do not give 24 hours advanced notice before missing an appointment, I understand that I may be charged a $25 missed appointment fee.

Parent or Guardian Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices

Please initial each item and sign below.

_____ I have received a copy of the notice of Privacy Practices for Sustaining Health Acupuncture.

Parent or Guardian Signature: _____ Date: _____

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 the patient named below, for whom I am legally responsible) by either Jacqui Kinzig and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associate with or serving as back-up for Jacqui Kinzig, including those working at Sustaining Health Acupuncture.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, supplement recommendations, and nutritional counseling. I understand that herbs may need to be prepared and consumed according to the instructions provided. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated 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 and gua sha. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although same may be toxic.

I understand that results are not guaranteed.

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 treatment, and have had an opportunity to ask questions. I intend for this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I may seek treatment.

_____ _____

Signature of Patient (or Patient Representative) Date

Sustaining Health Acupuncture
Notice of Privacy Practices

THIS NOTICE DESRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your protected health information (PHI) may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we may consult with your primary care physician regarding your case.

Payment: Your PHI may be used to seek payment for services provided to you. For example, we may send a report of progress to your insurance company.

Health Care Operations: Your PHI may be used as necessary for normal healthcare operations. For example, your address will be stored on our computer, and we may contact you via address or telephone.

Law Enforcement: Your PHI may be disclosed when required by law.

Other Uses and Disclosures: Except as above, your PHI will be made only with your consent, authorization or opportunity to object unless required by law. If you change your mind after authorizing a use or disclosure of your PHI you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Your Rights

You have certain rights under the federal privacy standards. These include:

- The right to inspect and copy your PHI.
- The right to request a restriction on the use and disclosure of your PHI.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to amend or submit corrections to your PHI.
- The right to receive an accounting of how and to whom your PHI has been disclosed.
- The right to receive a printed copy of this notice.

Sustaining Health Acupuncture, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all PHI we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practies, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Sustaining Health Acupuncture, LLC
1795 Alysheba Way #1102
Lexington, KY 40509

Effective Date

This notice is effective on or after July 31, 2012.