<u>Children's Personal History Intake Form</u>

Date: ___________________________

Name of the Child:____

Names of the Parents: ____

Names of Siblings (Include Ages):

____

____

Address:____

City:_________________________________ State:________

Zip:________________________

Phone:____

What are the main concerns you wish to address?:

1.____

2.____

3.____

<u>Child's Health:</u>
Has your child had any of the following illnesses? Check all that apply:

Mumps___ Measles ____ Chicken-pox ____ Polio ____ Glandular fever ____
Mononucleosis_____ Pneumonia____ Eczema____ Asthma____ Cancer_____
Tuberculosis____ Gonorrhea____

If you child has had any of the following immunizations, place an (X) on the appropriate line and/or give the (approximate) year:

Year	Immunizations	Year	Immunizations
______	Mumps	______	Smallpox
______	Measles	______	Tetanus
______	Chicken Pox	______	Polio
______	Hepatitis	______	Flu

Other:

____

Has your child ever had any reactions to vaccination? Yes No If Yes, describe:

____

____

Current medications, if any:

____

Operations or Major Injuries, if any:

1.____when____________________

2.____when____________________

3.____when____________________

Other____

Does your child have any allergies? If yes, please list:

____

____

____

Has your child had any of the following? Check any that apply:

jaundice____	lack of energy____	colic____
hyperactivity____	sleeping problems____	learning problems____
nervousness____	tantrums____	constipation/diarrhea____
convulsions____	heart problems____	digestive upsets____
skin rashes____	vision problems____	speech problems____
asthma____	behavior problems____	eczema/psoriasis____
ear infections____	allergies____	bedwetting____
croup____	teething problems____	frequent or recurrent illnesses_____
injuries/burns____		

explain:____

Other:

____

Mother's pregnancy

Did you have any difficulty conceiving? ____Yes ____No

Describe any problems you had during pregnancy:

____

____

____

Describe your emotional state during pregnancy, including any stresses that you had:

____

____

____

____

Check all that apply to describe your labor: ____Vaginal delivery ____Caesarian section ____Forceps delivery ____Used suction ____Episiotomy ____Epidural ____Analgesics ____Fetal distress ____Water birth ____Home birth ____Had midwife

Please describe any complications during labor:

____

____

How long were you in labor for?

____

What did you use for pain relief during labor?

____

Did you breast feed? ____Yes ____No If Yes, for how long?: ____________________

Please list any medications or supplements that your child is taking or has taken recently:

Patient Agreement and Disclaimer:

I understand that a block of time has been set aside for my private appointment, and that a 24-hour notification is required if I must cancel. I understand that there is a full charge for appointments canceled less than 24 hours in advance. I understand that payment is due by check, credit card or cash at the time services are rendered, unless other arrangements have been made prior to the appointment.

By signing below, I do hereby voluntarily consent to be treated with acupuncture, substances from the Oriental Materia Medica, and/or substances from the Homeopathic Materia Medica by a licensed acupuncturist and certified homeopath at the Essential Wellbeing Clinic. I understand that acupuncturists and homeopaths practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I confirm that any prescriptions/medications I am taking under the care of a physician will not be withdrawn without his/her supervision.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs/Homeopathy: I understand that substances from the Oriental Materia Medica and Homeopathic Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Essential Wellbeing Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

I HAVE READ THE ABOVE AND AGREE TO ALL TERMS:

Child's name: ______________________________________

Parental Signature: ____________________________________ Date: ___________

If patient is under 18 years, parental signature is required.

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Education and Experience

Elizabeth Astor earned her Master of Acupuncture and Oriental Medicine degree from Southwest Acupuncture College in 2011. This four-year program consists of 3,500 hours of education, including 1,000 hours of clinical practice. She was certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2011. This includes certification in Clean Needle Technique and Chinese Herbology. Elizabeth's training includes adjunctive therapies such as herbology, moxibustion, tui-na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Elizabeth received her professional practitioner certification in Classical Homeopathy (CHom) in 2009 from the Homeopathy School International. This two-year program consists of 500 hours of education including 250 hours of clinical casework.
Elizabeth is a member of the Acupuncture Association of Colorado and the American Association of Oriental Medicine. She is a licensed acupuncturist in Colorado. None of these licenses, certificates, or registrations has ever been suspended or revoked. This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

- Initial Consultation and Treatment: $220+ cost of herbs or homeopathic remedies
- Follow-up Treatment: $130 (60 min.) + cost of herbs or homeopathic remedies
- Acute Phone Consultation (for current clients): $3 per minute

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

_____(Initial) I agree to receive text messages to this mobile phone number (____) ____-______ reminding me about my upcoming appointments with Essential Wellbeing. I understand that SMS reminders are optional and that message and data rates may apply. Email reminders are also available.

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Patient or Guardian's Signature Date