If completing electronically, please download this form, save it to your computer and then fill out the form, saving as you go.
When you've completed the form, email as an attachment to confidential@balancedhealth.co

BALANCED HEALTH
Acupuncture & Wellness Clinic

#204 2nd Floor
926 7th Avenue
Invermere, BC

☎ (250) 341-4806
(250) 341-4807
info@balancedhealth.co

At Balanced Health Acupuncture & Wellness Clinic, we believe that looking after ourselves is not only important, but necessary. Our core practice is acupuncture, part of the age-old Chinese medical system that uses needles to stimulate Qi. Balanced Health offers a holistic Eastern approach to health that is an effective complement to Western Medicine.

CONFIDENTIAL INTAKE FORM
PEDIATRIC CLIENTS

Patient's Name: DOB: Sex: M F

Address:

City: Province: Postal Code:

Mother's Name and Occupation:

Father's Name and Occupation:

Contact Email: Home:

Work: Cell:

Emergency Contact:

Parents are: Married Separated Divorced Other:

I give Balanced Health Acupuncture & Wellness Clinic permission to email me appointment notifications and occasional announcements.

Referred by:

Reason for visit:

Has your child been seen by any other doctor(s) for this complaint? Yes No In the past

Please describe past care for this complaint:

Previous Pediatrician's Name and Phone:

Last time child had blood work done and what labs:

Any known allergies to food, drugs, environment, animals, etc:

List all surgeries and hospitalizations, including date occurred:

List all medications (from drugstore or prescription) child is on now and dosages if known:

List all supplements child is now taking, and dosages if known:

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MEDICAL HISTORY

YES indicates the child gets the problem regularly
NO indicates the child never had the problem
IN THE PAST indicates the child had the problem in the past, but not recently

Ear infections: Yes No In the past
If has had, how frequent per year:

Colds: Yes No In the past
If has had, how frequent per year:

Strep Throat: Yes No In the past
If has had, how frequent per year:

How many times has your child taken antibiotics:

Has your child had any of the following:
Chicken Pox Age
Rubella Age
Mumps Age
Whooping Cough Age
Rubeola Age

What medications has the child taken in the past and how often:

Hearing test normal: Yes No Not tested

Vision test normal: Yes No Not tested

Speech Impediments: Yes No In the past

Learning Impediments: Yes No In the past

VACCINATION HISTORY

Yes - Has had
No - Has not had
Some - Did not finish all shots
Homeprophylaxis - Was vaccinated homeopathically

M.MR: Yes No Some Homeoprophylaxis

DPT : Yes No Some Homeoprophylaxis

HepB: Yes No Some Homeoprophylaxis

Hib Yes No Some Homeoprophylaxis

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Chicken Pox: Yes No Some Homeoprophylaxis

Polio: Yes No Some Homeoprophylaxis

Others: Yes No Some Homeoprophylaxis

Any reactions to vaccinations? If so, please explain:

FAMILY HISTORY

Allergies: Yes No In the past

Cancer: Yes No In the past

Tuberculosis: Yes No In the past

Obesity: Yes No In the past

Mental Illness: Yes No In the past

Heart Disease: Yes No In the past

If answers yes to any of the above, please write relationship of family member to child and severity of the disease:

MOTHER'S PREGNANCY HISTORY

Age at conception: Length of Labour: Vaginal Birth: Yes No

Traumatic Birth: Yes No
If yes please explain:

Medications during pregnancy:

How many ultrasounds during pregnancy:

Birth interventions Forceps Vacuum Extraction C-section Induction None

During pregnancy did any of the following occur?
Smoking Recreational Drugs Preeclampsia Diabetes Emotional Stress
Coffee Nausea/Vomiting Alcohol

Dietary Restrictions during pregnancy: Yes No
If yes, please explain:

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HEALTH HISTORY OF CHILD

Gestational age at birth (weeks at birth): Apgar scores:

Birth Weight: Birth Length:

Complications after delivery: Yes No

If yes, please explain:

Location of Birth: Hospital Birthing Center Home

Child Breastfed: Yes No For how long: When put on formula:

What formula was used:

When was solid food introduced:

When was whole milk introduced:

Any food cravings:

First foods:

When did child walk: Talk: Develop teeth:

- Jaundice as a baby
- Colic
- Cradle Cap
- Anemia
- Eczema or Psoriases
- Stomach Aches
- Diarrhea
- Asthma
- Constipation
- Warts
- Finicky eating
- Nightmares
- Poor teeth
- Bed-Wetting
- Chronic sniffles
- Excessive Tantrums
- Bad foot odor
- Defiant
- Very sweaty
- Fears/Phobias
- Hyperactivity
- Diaper rash
- Growing pains
- Early Puberty

Any particular household stressor child has witnessed or gone through:

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ENVIRONMENTAL EXPOSURE

Has the child ever lived near a refinery, polluted area or in a home with lead paint? If so, what sort of pollution were they exposed to:

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health?

Does the child seem particularly sensitive to perfumes, gasoline or other vapors?

Do you spray pesticides, herbicides or other chemicals around your home?

What year was your home/apartment built?

TYPICAL DAY'S DIET

Breakfast:

Lunch:

Dinner:

Snacks:

OTHER QUESTIONS:

Please list any questions you would like the acupuncture physician to address during this appointment:

PRIMARY CARE PHYSICIAN

Name:

Phone:

SPECIALISTS

(OB, Gastroenterologist, Psychiatrist, Counselor, etc)

Name & specialty:

Name & specialty:

Name & specialty:

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

1. Sometimes after receiving an acupuncture treatment you may feel a little bit light-headed. If that is the case, please sit down for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed.

2. Occasionally you may get a small hematoma (a small dime sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern - it will go away in a few days. Gentle pressure applied to the site will stop any bleeding that is occurring under the skin.

3. We use only sterile disposable needles that are used once on each patient.

4. Occasionally after the cupping procedure is performed there may be bruising at the site of the cups. This will fade after a few days and is purely cosmetic in nature.

APPOINTMENT CANCELLATION POLICY

NO SHOWS AND LATE CANCELLATIONS LESS THAN 24 HOURS BEFORE APPOINTMENT TIME ARE SUBJECT TO A CANCELLATION FEE. Please initial:

My signature authorizes to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based on the facts known, is in my best interests. I intend for 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.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize to administer care to my Son/Daughter as they deem necessary.
I clearly Lmderstand that I have the right to refuse care and that I am personally responsible for payment of all costs associated with the treatment of care:

Parent or Guardian:

Date: