

JULIE DALBEC
MAOM, LIC.AC., OTR/L
WHERE TRADITIONAL AND MODERN MEDICINE
BECOME INTEGRATED

MARLBOROUGH WELLNESS CENTER
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PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

DATE: _____
NAME (LAST, FIRST): _____
ADDRESS: _____
CITY, STATE, ZIP: _____
HOME PHONE: _____
DAYTIME PHONE: _____
EMERGENCY CONTACT NAME/PHONE: _____
DATE OF BIRTH: _____ CHRONOLOGICAL AGE (YEARS, MONTHS): _____
REFERRED BY: _____

HAS THE CHILD BEEN TREATED BY ACUPUNCTURE/ORIENTAL MEDICINE BEFORE? YES NO
HAVE THEY BEEN TREATED WITH SENSORY INTEGRATION TREATMENTS BEFORE? YES NO
MAIN CONCERN(S) YOU WOULD LIKE US TO ADDRESS: _____

WHEN DID THIS BEGIN? _____
HOW DOES IT INTERFERE WITH THEIR DAILY ACTIVITIES (I.E.: WORK/SCHOOL, SLEEP, PLAY)? _____

HAVE THEY BEEN GIVEN A MEDICAL DIAGNOSIS FOR THIS PROBLEM? _____

WHAT OTHER TREATMENTS HAVE THEY TRIED? _____

FAMILY MEDICAL HISTORY (CIRCLE ALL APPLICABLE)

DIABETES CANCER HIGH BLOOD PRESSURE HEART DISEASE STROKE
SEIZURES ASTHMA ALLERGIES OTHER: _____

PAST MEDICAL HISTORY (OF THE CHILD)

SIGNIFICANT ILLNESSES (CIRCLE ALL APPLICABLE AND SPECIFIC DATES)

CANCER DIABETES HEPATITIS HIGH BLOOD PRESSURE HEART
DISEASE RHEUMATIC FEVER/CHILDHOOD DISEASES THYROID DISEASE
VENEREAL DISEASE OTHER: _____

SURGERIES: _____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ABUSE, ETC.): _____

ALLERGIES (DRUGS, METALS/CHEMICALS, FOODS): _____

MEDICINES TAKEN IN THE LAST 3 MONTHS (VITAMINS, DRUGS, HERBS): _____

HAVE THEY EVER BEEN ON A RESTRICTED DIET? IF YES, WHAT KIND AND WHY? _____

PLEASE DESCRIBE THEIR AVERAGE DAILY DIET:

MORNING: _____

AFTERNOON: _____

EVENING: _____

ARE THEY CURRENTLY ON ANY MEDICATIONS? IF YES, DESCRIBE WHAT AND WHY: _____

HOW MUCH WATER/JUICE/MILK DO THEY DRINK PER DAY? _____

ARE THERE ANY OTHER CONCERNS YOU WOULD LIKE US TO ADDRESS?

IN ALL THE AREAS LISTED BELOW, PLEASE CIRCLE IF THE CHILD HAS EXPERIENCED ANY SYMPTOMS IN THE PAST 3 MONTHS:

GENERAL

FEVERS SWEAT EASILY BLEED OR BRUISE EASILY CHANGE IN APPETITE

SUDDEN ENERGY DROP (IF YES, WHAT TIME OF DAY?) _____

POOR SLEEPING/INSOMNIA CHILLS WEIGHT LOSS/GAIN STRONG THIRST

FATIGUE NIGHT SWEATS CRAVINGS (IF YES, WHAT? _____)

SKIN AND HAIR

RASHES ITCHING CHANGE IN HAIR/SKIN TEXTURE ULCERATIONS ECZEMA HIVES

LOSS OF HAIR ACNE RECENT MOLES OTHER: _____

ANY CHILDHOOD DISEASES? (CHICKENPOX, ETC.) IF YES, WHAT? _____

HAVE THEY HAD ANY IMMUNIZATIONS? IF YES, WHAT AND WHEN?

HEAD/EYES/EARS/NOSE/THROAT

DIZZINESS GLASSES POOR/BLURRY VISION EYE STRAIN EYE PAIN

EYE SURGERIES (IF YES, WHAT? _____)

COLOR BLINDNESS FLOATERS (SPOTS IN FRONT OF EYES) NIGHT BLINDNESS

TINNITUS (RINGING IN EARS) EARACHES POOR HEARING (HEARING AIDS?)

HAS THE CHILD HAD A HISTORY OF EAR INFECTIONS? IF YES, HOW MANY AND WHAT WAS DONE TO ADDRESS THE PROBLEM? _____

HEADACHES/MIGRAINES (IF YES, WHERE LOCATED?): _____

SINUS PROBLEMS TEETH GRINDING CONCUSSIONS NOSE BLEEDS JAW CLICKS

RECURRENT SORE THROATS SORES ON LIPS/TONGUE OTHER: _____

DO THEY HAVE A TENDENCY TO CATCH COLDS/FLUS REGULARLY? IF YES, HOW FREQUENTLY PER YEAR? _____

CARDIOVASCULAR

BLOOD PRESSURE: HIGH OR LOW IRREGULAR HEARTBEAT COLD HANDS/FEET

HISTORY OF BLOOD CLOTS DIFFICULTY BREATHING SWELLING OF HANDS/FEET

PHLEBITIS CHEST PAIN FAINTING OTHER: _____

RESPIRATORY

COUGH BRONCHITIS DIFFICULTY BREATHING WHEN LYING DOWN ASTHMA

PRODUCTION OF PHLEGM (IF YES, WHAT COLOR?): _____

COUGHING BLOOD PNEUMONIA PAIN WITH DEEP BREATH OTHER: _____

GASTROINTESTINAL

NAUSEA VOMITING DIARRHEA CONSTIPATION GAS BELCHING BLACK STOOLS

BLOOD IN STOOLS INDIGESTION/"TUMMY ACHES" BAD BREATH RECTAL PAIN

HEMORRHOIDS BLEEDING GUMS ABDOMINAL PAIN/CRAMPS OTHER: _____

ARE THERE ANY FOOD AVOIDANCE ISSUES? IF YES, WHAT AND WHY (DO THEY EXPERIENCE CERTAIN SIDE EFFECTS AFTER EATING CERTAIN FOODS): _____

GENITOURINARY

PAIN UPON URINATION FREQUENT URINATION BLOOD IN URINE URGENCY TO URINATE
UNABLE TO HOLD URINE NIGHT URINATION (IF YES, HOW FREQUENTLY AND WHEN DID IT
START?): _____
KIDNEY STONES DECREASE IN FLOW SORES ON GENITALS OTHER: _____

REPRODUCTIVE (COMPLETE IF APPLICABLE FOR THE AGE OF THE CHILD)

IS THE CHILD PREGNANT? **YES NO**
IS IT POSSIBLE THEY COULD BE PREGNANT? **YES NO**
PREGNANCIES: # _____ LIVE BIRTHS: # _____ MISCARRIAGES: # _____
ABORTIONS: # _____ PREMATURE BIRTHS: # _____ DATE OF LAST PAP: _____
AGE OF FIRST MENSES: _____ DURATION OF MENSES: _____
IRREGULAR PERIODS SPOTTING BETWEEN PERIODS UNUSUAL CHARACTER (HEAVY, LIGHT)
PAINFUL PERIODS CLOTS VAGINAL DISCHARGE VAGINAL SORES BREAST LUMPS
ANY CHANGES IN BODY/PSYCHE PRIOR TO MENSES ONSET (PMS): _____
DOES THE CHILD PRACTICE BIRTH CONTROL (IF YES, WHAT KIND?) _____

MUSCULOSKELETAL (PLEASE CIRCLE AREAS WHERE THEY REPORT THE PAIN)

NECK BACK/SPINE HAND/WRIST SHOULDER ELBOW KNEE ANKLE HIPS
MUSCLE WEAKNESS NUMBNESS PARASTHESIAS (TINGLING) OTHER: _____

NEUROPSYCHOLOGICAL

SEIZURES DIZZINESS LOSS OF BALANCE LACK OF COORDINATION POOR MEMORY
CONCUSSION DEPRESSION ANXIETY BAD TEMPER EASILY SUSCEPTIBLE TO STRESS
HAS THE CHILD BEEN TREATED FOR EMOTIONAL CHALLENGES? **YES NO**
HAVE THEY EVER CONSIDERED OR ATTEMPTED SUICIDE? **YES NO**
ANY OTHER NEUROPSYCHOLOGICAL ISSUES? _____

COMPLETED BY: _____ (PARENT/CAREGIVER)