Cindy Haxel Acupuncture
MSTCM, Dipl.Ac., L.Ac.

# Pediatric Health History

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your child's condition, but may play a major role in diagnosis and treatment. All information is strictly confidential.

Date: ____/____/____

## General Patient Information

Child's Name: ______________________________________________________________

Birthdate: _________ Age: ____ Gender: ____ Grade: _____ Height: _____ Weight: ____

Guardian's Name(s): _________________________________________________________

Address, City, State Zip: _____________________________________________________

Primary Phone: ___________________ Secondary Phone: _______________________________

May we contact you or leave messages at these phone numbers? Yes No

If No, what is the best way to reach you? ________________________________________

Email address: ______________________________________________________________

How did you hear about our office? _____________________________________________

Child's Primary Physician: _______________________________ Phone: ______________________

Date of last medical exam: __/__/__ Type (physical etc.): ________________________________

Have your child ever been treated by acupuncture or oriental medicine before? Yes No

Main conditions/symptoms that brought you here today (list in order of significance)

1) ________________________________ 4) ________________________________

2) ________________________________ 5) ________________________________

3) ________________________________ 6) ________________________________

How long ago did these problems begin? __________________________________________

Any seemingly unrelated events occurring at the same time the above symptoms started: _______

_____________________________________________________________________________

To what extent do these problems affect your child's daily activities? _________________________

What kinds of treatments have you already tried? ___________________________________

How well have they worked? ___________________________________________________

## Prenatal Health and History

Mother's health at time of conception? Poor Fair Good Excellent ?

Father's health at time of conception? Poor Fair Good Excellent ?

Mother's health during pregnancy? Poor Fair Good Excellent ?

Mother's emotional state during pregnancy? Poor Fair Good Excellent ?

Mother's diet during pregnancy? Poor Fair Good Excellent ?

Did the mother receive medical care during pregnancy? Yes No ?

What was the mother's age at the time of the child's birth?

How many previous pregnancies and births did the mother have?

What was the mother's occupation during pregnancy?

Did the mother experience any of the following during pregnancy?

Bleeding High blood pressure Nausea Vomiting Diabetes Thyroid problems

Physical or emotional trauma Other: ______________________________________

Did the mother use any of the following during pregnancy?

Tobacco Alcohol
Recreational drugs: ____________________
Prescription medications: ____________________
Over-the-counter medications: ____________________
Vitamins and/or supplements: ____________________
Other: ____________________

Were any of the following interventions used during pregnancy?
Ultrasound Amniocentesis Chorionic Villi Sampling Triple Screen
Maternal Serum Screening Other: ____________________

**Birth History**

Term length: Pre-term (37 weeks or less): __________ weeks
Full-term (38-42 weeks): __________ weeks
Post-term (more than 42 weeks): __________ weeks

Location of birth: Hospital Home Birthing Center Other: ____________________

Type of birth: Vaginal C-section

Types of Intervention: Induced labour Use of forceps Epidural/Anesthesia
Episiotomy Other: ____________________

Any complications during delivery (e.g., breech delivery)? ____________________

Length of labour: _____ Birth weight: _____ APGAR score (0 to 10): 1 min ___ 2 min ___ 5 min ___

Did the child experience any of the following at or shortly after birth?
Jaundice Rashes Seizures Birth injuries: ____________________
Infections: ____________________
Difficulties with feeding: ____________________
Birth defects: ____________________
Other: ____________________

**Dietary History**

How was the infant fed? Breast fed Formula (type: __________) Other: ______________

How long was the infant fed this way? ____________________

Did the infant have any reactions to what they were being fed? Yes No ?

Foods were introduced before 6 months ____________________
Reactions? ____________________

Foods were introduced between 6 and 12 months ____________________
Reactions? ____________________

Did the child ever experience Colic? Yes No ?

If yes, how severe was the colic? Mild Moderate Severe

Please list any food allergies or intolerances that the child has: ____________________
____________________

Does the child have any dietary restrictions (vegetarian/vegan, religious, etc.)? ______________
____________________

Describe the child's usual diet on a typical day:
Breakfast: ____________________
Lunch: ____________________
Dinner: ____________________
Snacks: ____________________
Beverages (include total quantity): ____________________

Please describe the child's general eating habits (e.g., good appetite, picky eater, etc.):
____________________

______________________________________________________________________

## Medical History

Has the child ever experienced any of the following illnesses? Rubella Mumps
Measles Chickenpox Whooping Cough Asthma Scarlet Fever Polio
Rheumatic Fever Other: ______________________________________________

Has the child ever experienced any of the following conditions? Diaper Rash Cradle Cap
Diarrhea Constipation High fever Heat or cold intolerance Bedwetting
Frequent colds Ear infections (How Many / How Often? ________________________)

Has the child received any of the following vaccinations?
DPT MMR HIB Polio TB Flu Smallpox Pneumovaccine
Chickenpox Other: ______________________________________________

Did the child have any adverse reactions to, or chronic illness, following vaccination? __________
______________________________________________________________________

Has the child ever been hospitalized? Yes No ?
For what reason and for how long ______________________________________________
Has the child ever had any significant physical or emotional traumas? Yes No ?
Explain ______________________________________________________________
Please list any medications and/ or supplements the child is currently taking: ______________
______________________________________________________________________

Does the child have any known drug allergies? Yes No ?
If yes, please list: ______________________________________________________

## Health and Development

How was the child's health in the first year? Poor Fair Good Excellent ?
How is the child's health now? Poor Fair Good Excellent ?
At what age did the child first: Sit up ____ Crawl ____ Walk ____ Talk ____ Teeth _____

## Sleep Patterns

What time does the child usually go to bed? ____________________________________
What time does the child usually wake in the morning? ______________________________
Does the child nap during the day? Yes No If yes, what time: ________________________
Does the child have nightmares? Yes No How often? ___________________________
Any problems with sleeping? (trouble falling asleep, trouble waking up, etc.)?
______________________________________________________________________

## Social Patterns

Is the child in: School Daycare Home Care Other: ___________________________
Child's behaviour at school? ______________________ At home? ______________________
What are the child's interests and favourite activities? ______________________________
What, if any, recreational activities are the child involved in? __________________________
______________________________________________________________________

How would you describe the child's temperament/personality? _________________________
Is there anything that you would want to change? __________________________________
Does the child exercise regularly? Yes No How muh/how often? ____________________
How often does the child read (not for school), or How often does someone read to the child?
Daily Several times a week Weekly Less than weekly

## Family History

Please indicate if a patient or a close relative (parent, grandparent, sibling) has had any of the following:

| | | Child | Relative |
|---|---|---|---|
| Allergies | Type ________________________ | | ____________________ |

Anemia ______________________________
Arthritis Type ______________________________ ______________________________
Asthma ______________________________
Birth Defects Describe ______________________________ ______________________________
Bleeding Disease Type ______________________________ ______________________________
Cancer Type ______________________________ ______________________________
Chicken Pox ______________________________
CVA/Stroke ______________________________
Depression ______________________________
Type I Diabetes ______________________________
Type II Diabetes ______________________________
Eczema ______________________________
Emphysema ______________________________
Epilepsy ______________________________
Glaucoma ______________________________
Heart Disease Type ______________________________ ______________________________
Hemophilia ______________________________
Hepatitis ______________________________
High Blood Pressure ______________________________
High Fever (frequent) ______________________________
HIV/AIDS ______________________________
Jaundice ______________________________
Juvenile Arthritis ______________________________
Kidney Disease Type ______________________________ ______________________________
Liver Disease Type ______________________________ ______________________________
Lung Disease Type ______________________________ ______________________________
Measles ______________________________
Meningitis ______________________________
Mental Illness ______________________________
Migraines ______________________________
Mononucleosis ______________________________
Mumps ______________________________
Nervous Disease ______________________________
Paralysis ______________________________
Pneumonia ______________________________
Polio ______________________________
Psoriasis ______________________________
Rheumatic Fever ______________________________
Rubella ______________________________
Scarlet Fever ______________________________
Seizures ______________________________
Spleen Disease Type ______________________________ ______________________________
Stomach Disease Type ______________________________ ______________________________
Stroke ______________________________
Thyroid Disease Type ______________________________ ______________________________
Tuberculosis ______________________________
Vein conditions Type ______________________________ ______________________________
Whooping Cough ______________________________
Other ______________________________ ______________________________
Family Medical History is unknown ______________________________

Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship L/D Age Diseases Suffered/ Cause of Death

Mother ____________________________________________

Father ____________________________________________

Maternal Grandfather ____________________________________________

Maternal Grandmother ____________________________________________

Paternal Grandfather ____________________________________________

Paternal Grandmother ____________________________________________

Sister(s) ____________________________________________

Brother(s) ____________________________________________

Maternal Aunts ____________________________________________

Maternal Uncles ____________________________________________

Paternal Aunts ____________________________________________

Paternal Uncles ____________________________________________

Do either of the parents of the child have a chronic illness? Yes No

If yes, please describe: ____________________________________________

____________________________________________

**Home Environment**

Are there any pets in the home? Yes No

If yes, what type and how many? ____________________________________________

Does anyone in the child's household smoke? Yes No

How is the child's home heated? ____________________________________________

Do you know of any toxins or other hazards that the child is regularly exposed to? Yes No

If yes, please describe: ____________________________________________

How would you describe the emotional climate of the child's home? ____________________________

____________________________________________

Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ____________________________________________

____________________________________________

Is there anything that you feel is important that has not been covered? ____________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________ ______________

Patients (Guardian's) Signature Date

Cindy Haxel Acupuncture
MSTCM, Dipl.Ac., L.Ac.

# Mandatory Disclosure

Education and Experience

Cindy Haxel earned her Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in August 2007. This 4-year program consists of 2850 hours of education including 1080 hours of clinical practice. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in September 2007. This includes certification in Clean Needle Technique.

Cindy's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and diet and lifestyle recommendations. She also has specialized training in Cosmetic Acupuncture and Pediatrics.

Cindy is a member of the American Association of Oriental Medicine. She received her acupuncture license in Colorado in 2007. Her license, certificates, or registrations have never been suspended or revoked.

This clinic complies with the rules and regulates promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are used.

Fee Schedule

| | Per session | Discount Packages * |
|---|---|---|
| Cosmetic Acupuncture | $85 | $725 for 10 sessions |
| Initial Intake | $95 | |
| Follow-up Treatment / 60 minute | $60 | |
| Extended follow-up Treatment / 90 minute | $80 | |
| Pediatric Acupuncture | $45 | |

* The patient may terminate this treatment at any time and any unused treatments will be refunded at the discounted rate.

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.
- If at any time the patient wishes to terminate treatment and they have purchased a discount package they will be refunded in full for any unused treatments at the discounted rate.
- 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.

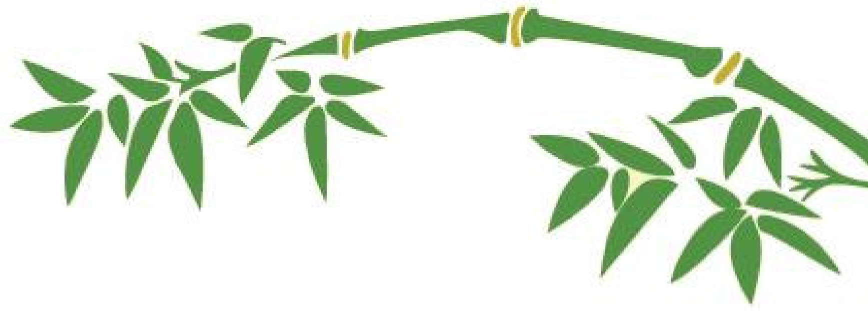
The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone 303-894-2440.

I have read and understand this document.

__________________________________ ____________

Patients (Guardian's) Signature Date

Cindy Haxel Acupuncture
MSTCM, Dipl.Ac., L.Ac.



# HIPPA Acknowledgement

**Cindy Haxel Acupuncture protects Your Health Information and Privacy**

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation or with other medical practitioners that you authorize.

Safeguards in place at this office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records are kept on permanent file

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us
- From your medical history, treatment notes, all test results, and any communication records to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators

In certain states, you may be able to access and correct personal information we have collected about you.

We value our relationships, and respect your right to privacy. If you have questions at all about our privacy policies, please call us at 303-956-5817.

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# HIPPA Consent Form

I give Cindy Haxel my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices of the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

**Signature:**_________________________________**Date:**______________________
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient______________________

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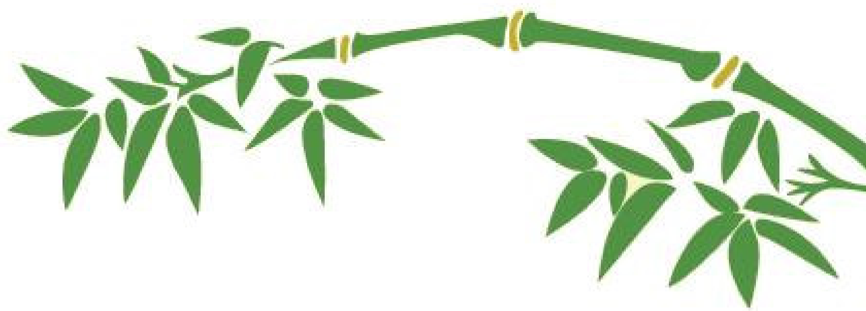

**INFORMED CONSENT TO ACUPUNCTURE TREATMENT AND CARE**

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including but not limited to, a punctured lung, infection, and bruising. 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 treatment that is in my best interest, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend 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.

*To be completed by the patient or patient's legal representative:*

________________________________________
Print patient's name

________________________________________ ______________________
Signature of patient or patient's legal representative Date

Relationship to patient, if patient's legal representative: ______________________