

Counterpoint Wellness, PLLC

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Today's date _____

Child's Name _____ Nickname _____

Age _____ Date of Birth _____ Place of Birth _____

Height _____ Weight _____ Gender _____

Name(s) of Parents/Caretaker(s) _____

Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Is it ok if we email you?: Yes No

Family Physician _____ Referred By _____

Emergency Contact _____ Phone _____

Has Your Child Been Treated By Acupuncture or Oriental Medicine Before?: Yes No

Has Your Child Been Treated By Craniosacral Work Before?: Yes No

Main Problem(s) that your child would like help with:

How long ago did this problem begin (be specific)? _____

To what extent does this problem interfere with your child's daily activities (school, sleep, etc)? _____

Has your child been given a diagnosis for this problem: If so, what?

What kinds of treatment has your child tried?

Past Medical History :

Problems with pregnancy or birth _____

Does your child have all recommended immunizations? _____

Any reactions to immunizations? _____

Surgeries (type of and date) _____

Significant Trauma (auto accidents, falls, etc) _____

Significant Dental Work (type and date) _____

Any Mesh, Metal, or Other Material Implanted In Child's Body Yes No

Location(s) _____

Allergies (drugs, chemicals, foods, latex)

Medicines taken within the last two months (drugs, vitamins, herbs, supplements, etc):

Name of Medication/Supplement

Reason for Taking It

Has your child taken many courses of antibiotics over her/his life? If Yes, for what reasons?

Would you say your child's appetite is good _____, **medium** _____, **small** _____

Is your child a choosy eater? In what ways? _____

Has your child ever been on a restricted diet? Yes No What Kind? _____

Does your child suffer from any of the following?:

General

- Fevers
- Sweat easily
- Sweating after feeding
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Strong thirst (cold or hot)
- Sudden energy drop - what time of day? _____
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
 - Itching
 - Dandruff
 - Change in hair or skin
 - Ulcerations
 - Eczema
 - Loss of Hair
 - Hives
 - Pimples
 - Other hair or skin problems
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Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Glasses
- Poor vision
- Eye pain
- Color blindness
- Discharge from ears
- Frequent ear infections
- Earaches
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions
- Poor hearing
- Nose bleeds
- Facial pain
- Tonsillitis

- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when _____
- Other head or neck problems _____

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____

Respiratory

- Cough
- Bronchitis
- Production of phlegm what color _____
- Coughing blood
- Pneumonia
- Asthma
- Other lung problems _____

Approximately when was your child's last cold or flu?

Gastrointestinal

- Colic
- Nausea
- Constipation
- Black or green stools
- Bad breath
- Abdominal pain or cramps
- Vomiting
- Gas
- Swollen abdomen
- Blood in stools
- Diarrhea
- Belching
- Teething problems
- Other stomach or intestinal problems _____

Genito-urinary

- Pain on urination
- Blood in urine
- Leakage in the day
- Bedwetting
- Does your child wake up to urinate? Yes No. How often? _____
- Any particular color to your child's urine? _____
- At what age was your child toilet-trained? _____
- Has your child started her menses yet? _____
- Any menstrual difficulties or irregularities? _____
- Other genital or urinary system problems _____

Musculoskeletal

- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

Neuropsychological

- Seizures
 - Areas of numbness
 - Bad temper
 - Difficulty concentrating
 - Vacant
 - Moody
 - Aggressive
 - Temper tantrums
 - Dizziness
 - Lack of coordination
 - Depression
 - Loss of balance
 - Anxiety
 - Developmental disability
 - Late developer
 - Other neurological or psychological problems
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