Kelly McConville, Licensed Acupuncturist
12709 Poway Rd. #205
Poway, CA 92064
858-254-4781

Date: _____

CHILDÆS HEALTH HISTORY QUESTIONNAIRE
Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of
your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to
bring to our attention which is not asked on this form, please note it in the Comments section.
Thank you.

YOUR CHILDÆS NAME: _____DATE OF BIRTH_____

PLACE OF
BIRTH_____HEIGHT_____WEIGHT_____

MOTHERÆS NAME_____FATHERÆS NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

YOUR PHONE_____IN EMERGENCY CONTACT_____PHONE_____

FAMILY PHYSICIAN_____REFERRED BY_____

Your childÆs main
problem:_____
_____
When did this problem start?:
_____
_____
What treatments have you
tried?_____
_____
Past medical history:
Surgery_____
_____
Trauma (accidents requiring significant
medication)_____
_
Other_____
_____

Any problems with:
Pregnancy_____Birth:_____
_____
Please list immunizations, with dates and any reaction you noticed:
DPT: 1st_____2nd_____3rd_____
Reactions_____
APV 1st_____2nd_____3rd_____
_____
MMR 1st_____2nd_____3rd_____
_____
Others 1st_____2nd_____3rd_____
_____
What medication is your child taking (orthodox and
complementary)?_____

Has s/he had many courses of antibiotics? Lots:
_____Medium_____Few_____None_____
Allergies (drugs, chemicals,
foods)_____
_____
Does your child wake at night? _____How many
times?_____
DIET. Would you say that your childÆs appetite was:
good_____medium_____small_____ Is s/he choosy over food? (Y / N)_____
How much does your child have of the following each day? Cows
Milk_____Cheese_____Cola_____
Juice_____Oranges_____Bananas_____Sugar_____Swee
ts_____
Does s/he take dietary supplements?:_____If so
which type?_____

GENERAL
___Recurrent infections
___Sweating___Sweating on head___Sweating after feeding___Strong thirst
___Fatigue___Sudden energy drops
___Underweight

SKIN___Pimples
___Rashes____Itching
___Eczema
___Oozing___Pimples

HEAD EYESEARS NOSE THROAT

___Tonsillitis
___Headaches___Earache___Discharge from ear___Vision problems
___Squint
___Spectacles
___Sore eyes
___Watering eyes___Nose bleeds___Nasal discharge___Blocked nose
___Snoring
___Sore throats___Tonsillitis

DIGESTION

___Colic
___Loose Stools
___Evil smelling stools
___Green stools
___Constipation (does not go every day)
___Painful to pass stools
___Gas
___Swollen tummy
___Protruding umbilicus
___Other digestive problems
___Teething Problems

GENITO-URINARY

___Pain on urination
___Blood in urine
___Leakage in day
___Wets bed
___Rashes

MUSCULOSKELETAL

___Wry Neck
___Aching Back
___Clicky Hips
___Overweight
___Hernia

NEUROLOGICAL

___Seizures
___Nerve damage
___Paralysis

DEVELOPMENTAL

___Small for age
___Large for age
___Late developer
___Retarded

BEHAVIORAL
___Difficulty in concentrating
___Vacant
___Moody
___Aggressive
___Temper tantrums
___Autism
_____Other

WHAT THERAPIES HAVE
YOU TRIED?
___Acupuncture
___Homeopathy
___Herbology
___Naturopathy

ANYTHING ELSE

_____
_____
_____

_____
_____

COMMENTS
_____
_____
_____
_____
_____
_____
_____

RESPIRATORY
___Phlegm
___Recurrent cough
___Bronchitis
___Pneumonia
___Asthma