Healing Tree
natural medicine

9 York Street
Point Frederick 2250
0431 625 784
Info@healingtreenaturalmed.com.au

Patient Information All information will be kept strictly confidential **Date: _____/_____/_____**

Name: _____ Male/Female DOB: _____/_____/_____

Parent/Guardian Name/s: _____ Relationship: _____

Address:

_____

Phone (mobile): _____ Email: _____

Height: _____ Weight: _____

Name/s and age/s of siblings:

_____

How did you hear about us? □ Google □ Professional Referral □ Word of mouth □Other: _____

Please describe the specific reason for your visit today and other health concerns:

1. _____
2. _____
3. _____

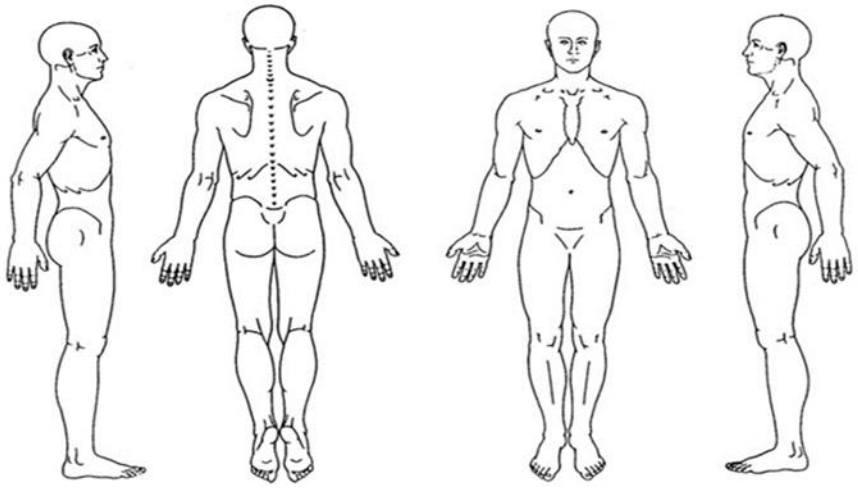
Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Has the child/infant had acupuncture treatment before? □ Yes □ No

Pain related issues

Indicate painful or distressed areas. Please **rate pain** on a scale of 1 (No pain) to 10 (Worst pain).



□ **Injury history**
□ **Pain gets worse** when cold / rainy / hot / humid/ tired/ moving / staying still/ at night / in the morning.
□ **Nature of pain:** Severe / Sharp / Stabbing / Dull / Cold / Hot / Aching / Throbbing / Sore

List all major past/present illnesses and allergies:

_____

_____

Have they had any surgeries/operations, major accidents or injuries, please explain:

_____

_____

List any major disease or illness in their immediate family and indicate family member (siblings, parents, grandparents):

_____

_____

List all **medications or supplements**, including herbs and vitamins they are currently taking (**dose and brand**):

_____

_____

Please explain your child's general temperament: _____

_____

Did you experience any pregnancy complications? _____

_____

What's your child's birth weight? _____ Birth details/complications? _____

Was your child breastfed? _____ How long? _____

Was your child formula fed? Which formula? _____

What age were solids introduced? _____ What age was your child toilet trained? _____

Were milestones achieved on time? _____

How much sugar/dessert do you eat per week? _____

_____

How much dairy do you eat per week? _____

_____

Any food that causes trouble? _____

_____

Patient Medical SYMPTOMS

Below are a series of health symptoms. Please check boxes with a **tick** for present symptoms and a **cross** for past symptoms. Please leave the box blank if they have never experienced this symptom.

Hot and Cold	Thirst	Sweat	Skin
☐ Cold hands/lower abdomen/feet ☐ Hot hands/feet/face/body ☐ Heat/Cold intolerance ☐ Face/body flushing ☐ Sensitive to light/sunlight	☐ Frequent thirst ☐ Not thirsty ☐ Drink cold water ☐ Thirst without desire to drink ☐ Dry mouth/throat	☐ Sweat easily ☐ Night sweat ☐ Damp hands or feet	☐ Dry Skin ☐ Easy bruising or bleeding ☐ Eczema/Skin rashes ☐ Psoriasis ☐ Slow wound healing
Urination	**Sleep**	**Emotional**	**Chest**
☐ Frequent urination ☐ Pain with urination ☐ Urination at night ☐ Dribbling urination ☐ Urgent urination ☐ Incontinence ☐ Difficulty starting urine ☐ Blood/cloudy/smelly urine ☐ Recurrent urinary tract infections	☐ Hard to fall asleep ☐ Waking during the night ☐ Dream disturbed sleep ☐ Waking un-refreshed ☐ Kicking blankets away while sleeping	☐ Difficult to settle ☐ Excessive whinging ☐ Depressed feeling or teary ☐ Poor concentration/focus ☐ Easily anxious ☐ Easily nervous ☐ Easily frustrated or angry ☐ High stress levels ☐ Scared and frightened easily	☐ Palpitation ☐ Shortness of breath ☐ Chest discomfort/pain ☐ Hypochondriac pain ☐ Frequent sighing ☐ Persistent cough
Bowel/Intestinal	**Digestion**	**Head**	**Body**
☐ Take supplement for bowel motion ☐ Bowel movement _____ time(s) per _____ day(s) ☐ Dry, hard or pebble-like stool ☐ Loose or watery stool ☐ Haemorrhoid history ☐ Loose stool in early morning	☐ Great appetite ☐ Tend to eat constantly ☐ Bloating/burping ☐ Gassiness/flatulence ☐ Indigestion ☐ Nausea ☐ Abdominal pain ☐ Food intolerance ☐Reflux/heartburn ☐ Tummy pain with cold food or drink	☐ Dizziness ☐ Headache/migraine ☐ Eye pain/tired/dry/ itchy/red ☐ Mouth ulcer ☐ Cold sores ☐ Tinnitus ☐ Ear infection ☐ Sore throat ☐ Sneezing/wheezing ☐ Runny nose ☐ Blocked nose ☐ Nose bleeding	☐ Recent sudden weight gain ☐ Gain weight easily without eating much ☐ Don't gain weight with lots of food ☐ Body feels heavy or more painful when weather is cold or wet ☐ Swelling or puffiness ☐ Numbness ☐ Fatigue/poor energy