Marcia Connelly, L.A.c., Dipl.OM
831. 818.7051
6892B Soquel Avenue Santa Cruz, CA 95062
MARCIA@MARCIACONNELLY.COM

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Pediatric Patient Information Intake **Today's Date____/____/______**

Patient Name:____ DOB:__________________

Sex: F M Age: _______ Height:_______ Weight_______

Parent/Guardian Name:___________________________________Marital Status: _________________________

Street Address:____

Mailing Address:____

City:_____________________________ State:_________ Zip: _____________ Email:_____________________________

Home phone:__________________________ Cell phone: _____________________________

Emergency Contact/ Phone: _____________________________________Phone number:_____________________

Insurance Carrier:_____________________________ Policy #_________________________Group#_____________

Name of Physician/P.A. /Health Practitioner: ____

How did you hear about us?____

Reason for today's office visit: ____

Is your child currently taking **prescription medication, herbs and/or supplements** (please circle)? **Yes No**
If yes, please list them:

1.______________________________	5.______________________________	9.______________________________
2.______________________________	6.______________________________	10._____________________________
3.______________________________	7.______________________________	11._____________________________
4.______________________________	8.______________________________	12._____________________________

List any of your child's known allergies? (environmental, seasonal, food, animals, medications):______________________

____

Had your child had any blood work done and what labs were completed? _______________________________________

____

Has your child had **any major medical events/hospitalizations?** (illnesses, surgeries, traumas, injuries, allergic reactions)
If so, please list them:

Major Health Complaints: Please list your child's top four (4) health concerns in order of priority.

1.______________________________ 2.______________________________

3.______________________________ 4.______________________________

Medical History

Please check the box above if your child had any of the following**: Measles, Mumps, Rubella, Chicken Pox**?

If any of these illnesses were checked, at what age did your child contract the illness? ____________________

How often has your child had to take antibiotics? ______________________________

Are there any other medications your child has had to take in the past, and if so how often? ____________________

____

Vaccination History: Please check what applies to your child: **Yes No Some Unfinished**

____

Were there any vaccine reactions? Please check. **Y / N** If yes, please describe. **Yes No**

____

Please place "C" or a "P" in front of all that apply to your child's CURRENT and PREVIOUS health history:

____Food Allergies ____Food Sensitivities ____Poor Appetite ____Excessive Appetite ____Colic
____Frequent Digestive Complaints (cramping, gas, nausea, vomiting) ____Loose Stools
____Frequent Constipation ____Frequent Diarrhea ____Sinus Congestion/Infections____ Headaches
____Seasonal Allergies ____Asthma ____Easily Short of Breath ____Poor/Weak Vision Issues ____Hyperactive
____Fatigued ____Frequent Colds/Illnesses ____Thrush ____Strep Throat ____Bronchitis
____Frequent Fevers ____Febrile Seizures ____Chronic Earaches/ Infections ____Chronic Coughs ____Night Sweats
____Poor Sleep/Insomnia ____Nightmares ____Unfocused ____Physically Uncoordinated ____Body Aches
____Frequent Skin Rashes ____ Eczema ____UTI/Urinary problems ____ Blood in Urine ____Anemia
____Surgeries ____Neonatal Jaundice ____Frequent Antibiotic Use ____Seizure Disorders ____Underweight
____Overweight ____Musculoskeletal Structural Issues ____Poor/Weak Hearing Issues ____Speech Issues
____Mood Swings ____Strong Body Odor ____Slow Development ____Premature Adolescent Development
____Anxiety/Depression/Emotional Imbalances ____Learning Impediments ____Undescended Testicles

Family Medical History: Please check any of the following that apply to the child's family medical history.

Allergies, Asthma, Obesity, Cancer, Tuberculosis, Heart Disease, Diabetes, Seizure Disorders, Mental illness

Please list any other diseases in your family:

Birth Story: Please check any of the following that apply to your child's birth.
Location of birth: Please check. **Home, Birthing Center, Hospital**

Please check all that apply**: vaginal delivery, c, section, interventions** (induction, forceps, vacuum), **traumatic birth**

Please briefly describe any conditions or complications for the child's mother in pregnancy, birth or postpartum period.
(i.e. pregnancy induced hypertension, gestational diabetes, placenta issues, postpartum depression, ect)

____

____

____

Was child breastfed? Please indicate. **Y / N** If yes, for how long? ____________

If no, name of formula(s) used____

Did your child have any difficulties w/breast feeding or reactions/digestive issues w/formula(s)? __________________

____

At what age was your child given its first foods? __________

What were your child's first foods? ____

____

Does your child have any food cravings? If yes please describe. ____________________________________

Please **BRIEFLY** list a typical day in your Child's Dietary Habits:

Breakfast:

Lunch:

Snacks:

Dinner:

Please check any of the following beverages your child drinks **daily**:

Soda Cow's milk Juice Soymilk Rice milk Almond milk Water Coffee Tea w/caffeine Herbal Tea Fruit Smoothies (non-dairy or dairy)

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INFORMED CONSENT

What to expect during your child's treatment(s):

I understand that a treatment can include: Shonishin (meridian stimulation to enhance immunity), other Non-Needle meridian stimulators, Acupuncture, Herbs, Cupping, and Moxabustion, and that there can sometimes be side effects to the above such as minor aching from the needles, temporary discoloration (pinkness, redness of the skin due to cupping, guasha (spoon rubbing techniques to promote circulation), and though rarely, bruising from treatment. Also possible side effects may include loose bowels, stomachache, or skin reaction from herbal treatments and that I have the right to refuse any of the above treatments for my child. A child who is not ready and willing for a treatment, will <u>never be forced</u> to receive treatments. If I have any questions or concerns about my child's treatment I agree to contact the practitioner, Marcia D. Connelly, to discuss any questions or concerns.

1. Sometimes after receiving an acupuncture treatment you may feel light-headed. If this is the case, please sit down in the waiting area, drink water and in a few minutes you will feel clear-headed and relaxed. If this feeling of light-headedness persists, please inform your practitioner, Marcia D. Connelly.

2. On rare occasions there are side effects from acupuncture that may include a small hematoma (bruise) after an acupuncture needle is removed. This is not a cause for concern and should go away in a few days. Gentle pressure applied to the site immediately after it is discovered during your treatment should help stop any bleeding under the skin. If soreness and discoloration persists please inform your practitioner, Marcia D. Connelly, so she can advise you on the proper care of bruises.

3. We use only sterile, surgical steel needles. They are used once on each patient and disposed of in a medical waste container.
4. Occasionally after the cupping procedure there may be bruising at the site(s) where the cups were placed. The colors of the cupping marks can range from pale pink to dark purple. The darker the color of the cupping mark, the longer it may take to clear. Please ask your practitioner, Marcia D. Connelly on the proper care of cupping marks and any possible bruising that may occur.

5. We use guasha (Chinese soup spoon rubbing technique) to stimulate the acupuncture channels and points. Occasionally this rubbing can leave strawberry like redness over the area that was stimulated. This is not a cause for concern, the redness will generally fade within a day. If soreness and redness persists, please inform your practitioner, Marcia D. Connelly.

I have read the items listed above. **Initials** __________

I hereby authorize *Marcia D. Connelly* to administer care to my son/daughter as they deem necessary. I understand that I have the right to refuse care for my child, and that I am responsible for payment of all costs associated with my child's treatment/care.

Parent/Guardian Signature:______________________________________ Date:____________________

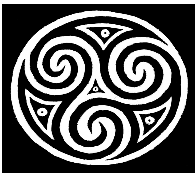
Signature of Practitioner: ______________________________________ Date: ____________________

<u>Office Policy</u>:

All fees for medical services are due at the time of visit unless prior arrangements have been made in writing. Acceptable forms of payment include: cash, check, credit card and insurance billing. If you need to cancel an appointment, please give a ***minimum of 24hrs notice****. There may be* ***a cancelation fee of $35 for less than 24hr notification and missed appointments****. Emergencies and sudden illnesses of child or parent/guardian will not be subject to this fee, but please call to notify Marcia of your cancelation.*

Please indicate your understanding and agreement to these policies by signing below.

Patient (or Representative/Guardian) Signature:_________________________________Date:________________



Marcia D Connelly, LAc, Dipl.OM

Live Oak Acupuncture & Healing Arts

Our Privacy Policy

Dear Valued Patient,
We do our best to protect 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 (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our 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 (including email, regular mail, telephone, and faxes sent) 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 (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (831) 818-7051.

Sincerely,

Marcia Connelly, L.Ac., Dipl.OM
Live Oak Acupuncture & Healing Arts, 6892B Soquel Ave, Santa Cruz, CA 95062

I consent to the use or disclosure of my identifiable health information by Marcia D. Connelly, L.Ac. (here after noted as Marcia) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Marcia may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Marcia is not required to agree to the restrictions that I may request. However, if Marcia agrees to a restriction that I request, the restriction is binding upon Marcia.

______________________________________ ________________
Signature of Patient or Authorized Representative **Date**

____
Printed Name and Relationshi