

(\*\*If you are sick with a cold or the flu at the time of your initial appointment, Dr. Martin suggests that you reschedule for another day\*\*)

**Dr. Randy W. Martin, Ph.D., L.Ac., O.M.D. - Lic. #CF002265**

*Doctor of Oriental Medicine - Classical Homeopathic Medicine  
Chinese Herbs - Acupuncture - Nutritional Counseling*

*Specializing in: Women's Health - Preventive & Holistic Medicine - Pain Control - Pediatrics - Allergies - Headaches*

Today's Date \_\_\_\_\_

Patient's First Name \_\_\_\_\_ Last \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_

Parent's E-Mail: \_\_\_\_\_ Pager or Cell Number \_\_\_\_\_

Parent's Driver's License No. \_\_\_\_\_ SS# \_\_\_\_\_

Child's Birthdate \_\_\_\_\_ Birth Place \_\_\_\_\_

Birth Time (if known) \_\_\_\_\_ Birth Weight \_\_\_\_\_ Current Height \_\_\_\_\_ Weight \_\_\_\_\_

Parent's Name \_\_\_\_\_ Parent's Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Who Should We Contact In Case of an Emergency? \_\_\_\_\_

Phone Number of This Person? \_\_\_\_\_ Relationship \_\_\_\_\_

Who should we thank for referring you to Dr. Martin? \_\_\_\_\_

**PLEASE READ AND SIGN:**

1. I understand that I am still responsible for payment in full even if I have insurance coverage. A monthly late charge of 1% will be applied to any unpaid balance from 30 days of the treatment date.
2. I understand that I personally am responsible to pay for any missed appointments unless I cancel them at least 24 hours in advance of the appointment (48 hours in the case of new patient first appt.)
3. I give Dr. Martin permission to treat my child using Oriental medicine, nutritional supplements, acupuncture, and/or homeopathy.
4. I consent and authorize Dr. Martin to transmit any information to my insurance company as

required or requested for Dr. Martin to receive insurance compensation in connection with my child's treatment.

My signature below indicates that I have have read and agree to the above:

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

Page 2

**The following information will be kept strictly confidential**

Has your child ever received homeopathic and/or acupuncture treatment? \_\_\_\_\_

If so, when and where? \_\_\_\_\_

**List the four (4) most important concerns you currently have about your child/teen's health:**

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**Please indicate the types of treatment you are interested in your child/teen receiving:**

\_\_\_\_\_ Homeopathy    \_\_\_\_\_ Acupuncture    \_\_\_\_\_ Herbs  
\_\_\_\_\_ Nutritional Counseling and Diet    \_\_\_\_\_ Whatever works best

List any prescription medications your child is currently taking: \_\_\_\_\_

\_\_\_\_\_

List any vitamins, herbs, or homeopathic remedies he/she is currently taking: \_\_\_\_\_

\_\_\_\_\_

List any past hospitalizations and/or operations and their approximate dates: \_\_\_\_\_

\_\_\_\_\_

List immunizations and reactions to the immunizations:

\_\_\_\_\_

---

May I contact you child's other doctors so we can work as a team? \_\_\_\_\_ (please list address/phone)

1. \_\_\_\_\_

2. \_\_\_\_\_

Has your child ever been in any type of psychological counseling? \_\_\_\_\_ If so, when, and for how long? \_\_\_\_\_

How often do they cry? \_\_\_\_\_ Scream and Yell? \_\_\_\_\_

Yawning frequently? \_\_\_\_\_ Easily Startled? \_\_\_\_\_

Were they breast fed? \_\_\_\_\_ how long: \_\_\_\_\_ Finger Sucking? \_\_\_\_\_

Page 3

How long was the mother's labor? \_\_\_\_\_ Mother's Health Problems at Birth \_\_\_\_\_

List the complications in labor and delivery? \_\_\_\_\_

Any medical problems during the pregnancy? \_\_\_\_\_

Did mother smoke \_\_\_\_\_, drink \_\_\_\_\_, or take any drugs \_\_\_\_\_ during the pregnancy? \_\_\_\_\_

What was the mother's attitude during the pregnancy? \_\_\_\_\_

What was the father's attitude during the pregnancy? \_\_\_\_\_

Was the child planned? \_\_\_\_\_ Has the child experienced grief? \_\_\_\_\_

=====

**Diet: Please check the items s/he eats and approximately how often each week:**

\_\_\_\_\_ Red Meat    \_\_\_\_\_ Fish    \_\_\_\_\_ Poultry    \_\_\_\_\_ Milk    \_\_\_\_\_ Junk Food

\_\_\_\_\_ Other dairy products    \_\_\_\_\_ Herbal Teas    \_\_\_\_\_ Regular sodas    \_\_\_\_\_ Chocolate

\_\_\_\_\_ Diet sodas    \_\_\_\_\_ Candy    \_\_\_\_\_ Cookies/Cakes    \_\_\_\_\_ Pickles    \_\_\_\_\_ Ice Cream

\_\_\_\_\_ Breast Fed Only    \_\_\_\_\_ Breast Fed with Formula (type of formula): \_\_\_\_\_

What foods does s/he prefer? \_\_\_\_\_

What foods will s/he not eat? \_\_\_\_\_

Do you or your child follow any of these diets?

\_\_\_\_\_ Vegan    \_\_\_\_\_ Pritikan    \_\_\_\_\_ Macrobiotic    \_\_\_\_\_ Vegetarian    \_\_\_\_\_ Junk Food

=====

How many hours does s/he sleep? \_\_\_\_\_      How does s/he feel when waking up? \_\_\_\_\_

Does s/he sleep with many covers \_\_\_\_\_ or few \_\_\_\_\_?    What position of sleep? \_\_\_\_\_

Are there nightmares? \_\_\_\_\_    Content \_\_\_\_\_

What things disturb your child? \_\_\_\_\_

What does s/he do when not getting their way? \_\_\_\_\_

=====

As the parent, have **you** \_\_\_\_\_, or **your** parents \_\_\_\_\_, or **your** grandparents \_\_\_\_\_, ever had:

\_\_\_\_\_ tuberculosis    \_\_\_\_\_ gonorrhea    \_\_\_\_\_ syphillis    \_\_\_\_\_ cancer : where \_\_\_\_\_

\_\_\_\_\_ headaches    \_\_\_\_\_ allergies    \_\_\_\_\_ stomach problems    \_\_\_\_\_ alcohol abuse

\_\_\_\_\_ moles and warts    \_\_\_\_\_ asthma    \_\_\_\_\_ been on anti-depression medications

\_\_\_\_\_ been smokers    \_\_\_\_\_ bronchitis    \_\_\_\_\_ skin rashes or hives    \_\_\_\_\_ emotional abuse

Page 4

**Please indicate problems which have affected you or your relatives:**

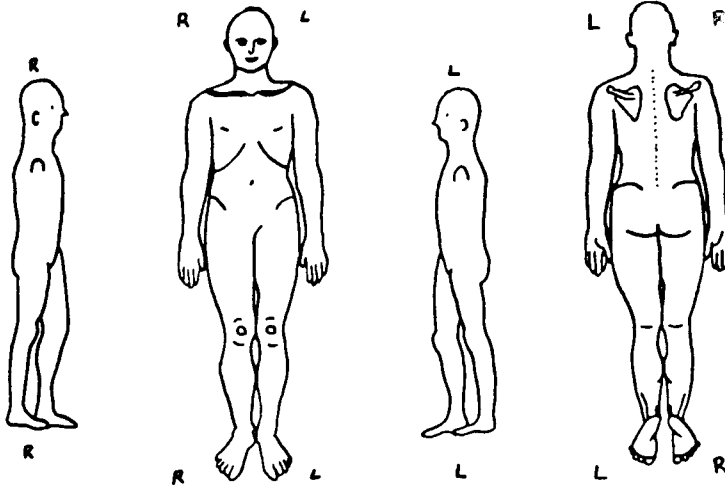
**Child's Mother** \_\_\_\_\_

**Child's Father** \_\_\_\_\_

Brother/Sister (of the child) \_\_\_\_\_

**Child's Grandparents** \_\_\_\_\_

**If your child is in pain, please indicate exactly where the pain is on this chart:**



**Please check a "P" for past or "N" for now for any symptoms your child has had:**

- Sweating for no reason; Where is the sweating? \_\_\_\_\_  
 Flatulence (colic/gas):  before  during  after eating  
 Burping or heartburn  Frequent colds/flu  Ear Infections: side \_\_\_\_\_  
 Allergies:  airborne  food; Specify: \_\_\_\_\_  
 Bronchitis  Asthma  Any Physical Shock? \_\_\_\_\_  
 Frequent use of antibiotics: For what problems? \_\_\_\_\_  
 Herpes:  Lips  Genital  Zoster  
 Other Skin Problems: Specify \_\_\_\_\_;  Skin Rashes? Where \_\_\_\_\_  
 Moles or Warts: Where? \_\_\_\_\_  
 Moles or warts removed? \_\_\_\_\_ Where/When? \_\_\_\_\_  
 Cancer: Where and status \_\_\_\_\_  
 Hepatitis  Constipation  Conjunctivitis  
 Separation Anxiety  Hides face in blankets  Hot or  Cold hands

**Please check a "P" for past or "N" for now for any symptoms/problems the child has had:**

- Diarrhea  Candiada  Thrush  Cradle Cap  
 Headaches: How often and what part of the head \_\_\_\_\_



---