KWAN YIN HEALING ARTS CENTER

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Vaccination Consultation Intake

Please answer the following questions, to the best of your ability, for your baby or child. If a question does not apply, please write NA.

Due date (if pregnant):

Child was (check one)______ preemie (# weeks ________) or __________ full-term

Please describe the birth:

Breastfed? How long? (Or, are you planning to & for how long?)

When was food introduced, and what was introduced first?

Does the child have siblings? Ages?

What do the parents of the child do for work?

Does anyone in the home smoke cigarettes or a pipe?

Describe the health history of the child, what types of illnesses has s/he had?

What is the ethnicity of the child?

PATIENT NAME:____ PATIENT DOB:_____________________

Has the child been given antibiotics for any illness? How many times?

Is the child now in, or will be in, a daycare setting?

Did Mom have vaccines to (circle Y or N, or had illness):

Diptheria	Y / N / had illness
Tetnus	Y / N / had illness
Polio	Y / N / had illness
Measles	Y / N / had illness
Mumps	Y / N / had illness
Rubella	Y / N / had illness
Hepatits B	Y / N / had illness

Please list other vaccines Mom has had: ____

Please list your thoughts / concerns about vaccines:

Is there a history of the following in your immediate family (yourself, your siblings, or your parents?)

Allergies	Y / N
Asthma	Y / N
Frequent infections	Y / N
Autoimmune disease	Y / N

Please describe the parents' diet / food preferences:

PATIENT NAME:_____________________________________ PATIENT DOB:_________________