Today's Date: _____

WHO IS FILLING OUT THIS FORM?

_____ _____
Name (Please print) Relationship to child

PATIENT INFORMATION

Name: _____ _____ _____
First name Middle name Last name

How would you like us to address the child? _____

Date of Birth (MM/DD/YYYY): _____ Current Age: _____ Sex: _____

Address: _____ _____
Street address Apartment #

_____ _____ _____
City Postal code Province

Please provide your contact information below and indicate whether or not we may leave messages relating to the child's appointments:

		Message?			Message?
(H) phone			Cell		
(W) Phone			Email		

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone numbers: H: ( ) _____ OTHER: ( ) _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Website ☐ Referred by another patient ☐ Other (please specify:
☐ Walk-in/Clinic Patient ☐ Referred by staff member _____
☐ Pamphlet/Flyer ☐ Referred by health care provider _____

HEALTH CARE PROVIDERS

Please list the other health care providers from whom the child currently receives treatment:

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

Fax: ( )_____ Fax: ( )_____

Health care providers (continued)

Name: _____

Type of care: _____

Address: _____

_____

Phone: ( )_____

Fax: ( )_____

Name: _____

Type of care: _____

Address: _____

_____

Phone: ( )_____

Fax: ( )_____

Does the child have regular screening tests with another Doctor (e.g. yearly physicals, etc.)? Yes No

CHIEF CONCERNS

Please list the top health care concerns for which you are seeking treatment in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY

How is the child's general state of health? Excellent Good Average Fair Poor

Please list any past health concerns, including major illnesses, hospitalizations, surgeries, etc., with approximate dates:

1. _____

2. _____

3. _____

4. _____

Does the child have any allergies (medication, seasonal, environmental, etc.)? _____

_____

Please complete the following table regarding the child's medications and supplements:

CURRENT medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST medications			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Does the child use any over-the-counter (non-prescription) medications? Please list:

_____

_____

Please indicate which immunizations the child has received:

Common childhood vaccines (North America)

- ☐ DPT (Diptheria, pertussis, tetanus)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Polio
- ☐ Smallpox
- ☐ Tetanus booster – when? _____
- ☐ Hemophilus influenza B
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ "Flu" shot
- ☐ Other: _____ _____

Did any of the vaccines cause a negative reaction? Please describe: _____

_____

FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in the child's family. Include parents, siblings, grandparents, aunts, and uncles and specify maternal/paternal lineage.

Health condition	**Family member(s)**
Heart disease (heart attack, stroke, etc.)	
High blood pressure	
Diabetes	
Asthma	
Eczema or other skin condition	
Thyroid disease	
Arthritis/Rheumatism/other muscle or joint condition	
Cancer	
Blood disorder	
Environmental/seasonal allergies	
Other (please describe):	

☐ I don't know the child's family medical history

HEALTH & DEVELOPMENT

How was the child's health in his/her childhood? Excellent Good Average Fair Poor

Has the child entered puberty? No Yes - If Yes: Any health changes occurring with puberty of concern?

_____

Describe the child's sleeping pattern/ sleep difficulties: _____

_____

How would you describe the child's temperament? _____

_____

_____

How would you describe the child's behaviour and performance at school? _____

_____

_____

DIET

What does the child usually eat on a typical day? Please indicate examples and quantities.

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

_____

Beverages: _____

_____

Are the child's meals typically prepared at home or purchased? _____

Does the child have any food allergies, sensitivities, or intolerances (that you know of)? _____

_____

Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____

_____

ENVIRONMENTAL HISTORY

Is the child is currently in: ☐ Home-school ☐ Other: _____

☐ School: Grade _____

What is the child's activity level? Inactive Mildly active Moderately active Active

What are the child's favourite activities? _____

_____

_____

How much TV does the child watch? _____ hours/week

How much time does the child spend at a computer/playing video games? _____ hours/week

Is the child exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through school, hobbies, home environment, etc.? _____

_____

Is the child frequently exposed to animals (including pets)? _____

_____

How is the child's home heated? _____

How would you describe the emotional climate of the child's home? _____

_____

_____

_____

Is there anything you feel is important that has not been covered? _____

_____

_____

_____

Thank you for taking the time to complete this form