

Date: _____

Name: _____	Age: _____	Date of Birth: _____
Address: _____	City: _____	Postal Code: _____
Home Phone: (____) _____	Work Phone: (____) _____	
Emergency Contact : _____	Phone: _____	

Referral Source (please circle any/all which apply)

- | | |
|--------------|-------------------------------------|
| Yellow Pages | Other media (TV, Newspaper article) |
| Website | Health Care Practitioner _____ |
| Street Sign | Friend/Family _____ |

Major health concerns/goals of treatment in order of importance

- _____
- _____
- _____
- _____
- _____

What medications, treatments or supplements are you currently taking?

- | | | |
|-------|--------------|------------------------------|
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |
| _____ | since: _____ | side effects/benefits: _____ |

Any recent immunizations? _____

Adverse reactions to any immunizations: _____

Which of the following conditions has your child had?

<input type="checkbox"/>	Abscesses	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	IBS	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	Warts
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Amnesia	<input type="checkbox"/>	Gall Stones	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Worms
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Goitre/Thyroid	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Sunstroke	<input type="checkbox"/>	Yellow Fever
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	Other(list here)
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Slow growth	<input type="checkbox"/>	
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Migraines or Headaches	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	
<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>	

ANY OTHER MAJOR CONDITIONS? _____

Are there any of the preceding conditions after which your child has never been totally well again or which have been more severe than usual? Which ones?

What surgeries/hospitalizations has your child had?

Type of Surgery/Hospitalization reason	Date/Year	Any Complications

What major injuries have your child had?

Injury	Date/Year	Long Term Effects

Have your child lost? or gained? any weight recently? (please circle which) How many pounds? _____

What exercise and how much? _____

Was your child breastfed? _____

Any problems as an infant ? please specify

Please indicate below, which of the following ailments have affected your relatives?

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhoea	Heart Disease	Pneumonia	Tuberculosis
RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS		
Mother:					
Father:					
Brothers:					
Sisters:					
Children:					
Maternal Grandmother					
Maternal Grandfather					
Maternal Aunts/Uncles					
Paternal Grandmother					
Paternal Grandfather					
Paternal Aunts/Uncles					

Do your child have any dietary restrictions? (vegetarian/vegan, religious, food allergies/intolerances etc.)
