

Please complete this form as thoroughly as possible prior to your first appointment.
The information you provide will be kept strictly confidential.

Contact information

date: _____

patient's name: _____ (first) _____ (last) sex: m f

date of birth: _____ (mm /dd /yyyy) height: _____ weight: _____

mother's name: _____ mother's occupation: _____

father's name: _____ father's occupation: _____

address: _____

city: _____ province: _____ postal code: _____

phone: home () _____ - _____ work () _____ - _____ ext _____ cell () _____ - _____

email: _____ may the clinic leave voice mail messages? yes no

Name and relation to child of person filling out this form: _____

emergency contact name: _____ relation: _____

phone: home () _____ - _____ work () _____ - _____ ext _____ cell () _____ - _____

How did you hear about the clinic? _____

Other healthcare provider

medical/family doctor: _____ phone: () _____ - _____

address: _____ fax: () _____ - _____

date of last visit: _____ (mm /dd /yyyy) permission to contact: yes no

other health care provider: _____

type of practitioner: _____ phone: () _____ - _____

address: _____ fax: () _____ - _____

date of last visit: _____ (mm /dd /yyyy) permission to contact: yes no

Medical history

List the patient's primary health concerns in order of importance:

1: _____ 3: _____
2: _____ 4: _____

Check the number that best represents the patient's general state of health on a scale of 5 (5 = excellent, 1 = very poor):

1 2 3 4 5

Please list medical conditions, illnesses, hospitalizations, along with treatment interventions (if applicable):

1: _____
2: _____
3: _____

Please list all of the patient's medications (past and current), include dose, duration, and side-effects, if any:

Also, please list all supplements, vitamins, minerals, herbal preparations, homeopathics, etc.:

Please indicate any allergies (medications, environment, foods):

How many times has the patient been on antibiotics? _____

What screening tests has the patient had (blood, hearing, vision, speech, learning etc.)?

Dietary history:

Please describe the patient's typical diet:

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

beverages: _____

patient was: breast fed formula fed, type _____ both for how long? _____

Please indicate newly introduced foods (in order of introduction) and any adverse reactions (e.g., bloating, gas, diarrhea, constipation, nausea, vomiting, or rashes):

1: _____ 2: _____

3: _____ 4: _____

current food allergies: _____

dietary restrictions (e.g., vegetarian, religious): _____

food cravings: _____

Is the patient thirsty?: yes no preference of drink temperature? cold room temperature hot

picky eater?: yes no number of meals per day: _____

How would you describe patient's appetite in general?: poor fair good excellent

Please describe the patient's dental history, including oral hygiene practice, grinding, number of cavities, fillings, etc.):

Immunization Record (Check all applicable)

DPT- Diphtheria, Pertussis, Tetanus	_____	Td + P - Tetanus, Diphtheria, Polio	_____
D-PTP -Diphtheria, Pertussis, Tetanus, Polio	_____	Tetanus	_____
OPV- Oral Polio Vaccine	_____	MMR- Measles, Mumps, Rubella	_____
Hepatitis B	_____	Hemophilus B	_____
Influenza (Flu Shot)	_____	Men-C conjugate	_____
Pneumo-coccal conjugate	_____	Varivax (Chicken pox)	_____
Other:	_____		

If the patient had an adverse reaction to any of the above vaccinations please describe reaction:

Family Medical History:

Has anyone in the patient's family had any of the following diseases? If yes, please indicate which member.

- | | | |
|---------------------------|---------------------------|--------------------------------|
| addiction _____ | depression _____ | lupus _____ |
| allergies _____ | diabetes _____ | obesity _____ |
| arrhythmia _____ | down syndrome _____ | rheumatoid arthritis _____ |
| asthma _____ | epilepsy _____ | sickle-cell anemia _____ |
| autism _____ | heart disease _____ | stroke _____ |
| autoimmune disorder _____ | high blood pressure _____ | ulcerative colitis _____ |
| bleeding disorder _____ | hypothyroidism _____ | cancer _____ |
| hyperthyroidism _____ | crohn's disease _____ | irritable bowel syndrome _____ |

other conditions not listed above:

mother: _____ father: _____ sibling(s): _____

grandparent (maternal): _____ grandparent (paternal): _____

Review of system

For each item, please place a check mark next to the symptoms the patient is currently experiencing in the "Yes" column. If they have experienced it in the past, please write the year in which the symptom was experienced in the "P (year)" column (i.e. 2007, or 1997-2001). Only fill out those that apply.

	Yes	P (year)		Yes	P (year)		Yes	P (year)
abdominal bloating	<input type="checkbox"/>	_____	dizziness	<input type="checkbox"/>	_____	measles	<input type="checkbox"/>	_____
acne	<input type="checkbox"/>	_____	ear ache	<input type="checkbox"/>	_____	meningitis	<input type="checkbox"/>	_____
ADHD or ADD	<input type="checkbox"/>	_____	early menses	<input type="checkbox"/>	_____	mononucleosis	<input type="checkbox"/>	_____
allergies	<input type="checkbox"/>	_____	eczema	<input type="checkbox"/>	_____	mumps	<input type="checkbox"/>	_____
anemia	<input type="checkbox"/>	_____	encephalitis	<input type="checkbox"/>	_____	nose bleeds	<input type="checkbox"/>	_____
anxiety	<input type="checkbox"/>	_____	eye crusting	<input type="checkbox"/>	_____	palpitations	<input type="checkbox"/>	_____
bedwetting	<input type="checkbox"/>	_____	fevers	<input type="checkbox"/>	_____	pneumonia	<input type="checkbox"/>	_____
bladder infection	<input type="checkbox"/>	_____	frequent infections	<input type="checkbox"/>	_____	psoriasis	<input type="checkbox"/>	_____
body odour	<input type="checkbox"/>	_____	frequent runny nose	<input type="checkbox"/>	_____	recurring ear infections	<input type="checkbox"/>	_____
bronchitis	<input type="checkbox"/>	_____	headaches	<input type="checkbox"/>	_____	rheumatic fever	<input type="checkbox"/>	_____
cancer	<input type="checkbox"/>	_____	heart murmur	<input type="checkbox"/>	_____	roseola	<input type="checkbox"/>	_____
chicken pox	<input type="checkbox"/>	_____	hemorrhoids	<input type="checkbox"/>	_____	rubella	<input type="checkbox"/>	_____
chronic colds	<input type="checkbox"/>	_____	herpes	<input type="checkbox"/>	_____	scarlet fever	<input type="checkbox"/>	_____
red and itchy eyes	<input type="checkbox"/>	_____	high blood pressure	<input type="checkbox"/>	_____	seizures	<input type="checkbox"/>	_____
cold sores	<input type="checkbox"/>	_____	HIV	<input type="checkbox"/>	_____	severe head injury	<input type="checkbox"/>	_____
colic	<input type="checkbox"/>	_____	hives or rashes	<input type="checkbox"/>	_____	strep throat	<input type="checkbox"/>	_____
colitis	<input type="checkbox"/>	_____	hyperthyroid	<input type="checkbox"/>	_____	spina bifida	<input type="checkbox"/>	_____
constipation	<input type="checkbox"/>	_____	hypoglycemia	<input type="checkbox"/>	_____	scoliosis	<input type="checkbox"/>	_____
cough or wheezing	<input type="checkbox"/>	_____	hypothyroid	<input type="checkbox"/>	_____	thrush	<input type="checkbox"/>	_____
crohn's disease	<input type="checkbox"/>	_____	impetigo	<input type="checkbox"/>	_____	ringing in the ears	<input type="checkbox"/>	_____
cradle cap	<input type="checkbox"/>	_____	indigestion/gas	<input type="checkbox"/>	_____	ulcers	<input type="checkbox"/>	_____
croup	<input type="checkbox"/>	_____	influenza	<input type="checkbox"/>	_____	ulcerative colitis	<input type="checkbox"/>	_____
cystic fibrosis	<input type="checkbox"/>	_____	insomnia	<input type="checkbox"/>	_____	urinary tract infections	<input type="checkbox"/>	_____
depression	<input type="checkbox"/>	_____	irritable bowel syndrome	<input type="checkbox"/>	_____	vomiting	<input type="checkbox"/>	_____
diaper rash	<input type="checkbox"/>	_____	jaundice	<input type="checkbox"/>	_____	whooping cough	<input type="checkbox"/>	_____
diphtheria	<input type="checkbox"/>	_____	joint pain	<input type="checkbox"/>	_____	warts	<input type="checkbox"/>	_____

Sleep:

Number of hours of sleep per day / night (including naps): _____ length of time it takes to fall asleep: _____

How would you describe the patient's sleep in general?:

poor fair good excellent

Please check if the patient experiences any of the following:

- dreams
- wakes up irritable
- night sweats / fever
- nightmares
- sleep-walking
- grinds / clenches teeth
- wakes often
- bed-wetting

comments: _____

Social / home environment:

parents: married separated divorced

siblings: yes no if yes, how many?: _____

Patient's living environment (house, apartment, new, old, newly renovated, etc.): _____

Is the patient exposed to any of the following? please check all that apply:

- cigarette smoke
- pets
- chemical (paint, new carpet, etc.)
- gasoline
- pesticides / herbicides
- mold

Please describe the emotional environment of the patient's home: _____

Daily activity:

Please check all applicable and indicate how often:

- reading _____
- video games _____
- family time _____
- television _____
- computer _____
- exercise _____

other: _____

Education:

patient currently in: daycare school home type of school: _____ grade: _____

Please describe patient's general disposition, interaction with others and performance in daycare/school/home?:

Please add any information you feel to be relevant that has not been covered: _____

Prenatal health

age of biological mother at time of patient's birth: _____

number of full-term pregnancies: _____ number of pregnancies not carried to term (miscarriage, stillborn, abortion): _____

was the pregnancy planned: yes no weight gained during pregnancy: _____

were there any fertility issues with this patient's conception? if yes, please explain: _____

emotional state of mother during pregnancy: _____

please list any medications and supplements taken during pregnancy: _____

complications during pregnancy, include any tests performed: _____

during the pregnancy, was the mother exposed to any of the following and if so, please indicate how much/often:

- | | |
|---|---|
| <input type="checkbox"/> alcohol _____ | <input type="checkbox"/> ultrasound _____ |
| <input type="checkbox"/> cold/flu _____ | <input type="checkbox"/> x-ray _____ |
| <input type="checkbox"/> infection (i.e. viral, yeast, group B strep) _____ | <input type="checkbox"/> amniocentesis _____ |
| <input type="checkbox"/> recreational drugs _____ | <input type="checkbox"/> chemical exposure _____ |
| <input type="checkbox"/> cigarette smoke _____ | <input type="checkbox"/> amalgam fillings put in/removed from teeth _____ |
| <input type="checkbox"/> over the counter medication _____ | <input type="checkbox"/> excessive stress _____ |
| <input type="checkbox"/> prescription medication _____ | <input type="checkbox"/> travel _____ |
| <input type="checkbox"/> herbal preparations _____ | |

please check any of the following complications during the pregnancy:

- | | | |
|---|---|--|
| <input type="checkbox"/> nausea | <input type="checkbox"/> maternal chicken pox | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> maternal cytomegalovirus | <input type="checkbox"/> bleeding | <input type="checkbox"/> maternal rubella |
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> maternal toxoplasmosis | <input type="checkbox"/> physical/emotional trauma |
| <input type="checkbox"/> thyroid dysfunction | <input type="checkbox"/> placenta previa | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> preeclampsia /eclampsia | | |

how would you describe the health of the mother during pregnancy?

- poor
 fair
 good
 excellent
 unknown

Natal history

place of birth: hospital home clinic other: _____

type of delivery: vaginal cesarean section was the labour induced?: yes no

length of labour: _____

length of pregnancy: full-term pre-term post-term premature: _____ weeks

at birth: weight _____ length _____ head circumference _____ APGAR score: _____

length of hospitalization of mother: _____ baby: _____

describe any physical or emotional complications with the delivery: _____

did breastfeeding begin immediately? yes no if no, when did it begin? _____

please check any of the following that applied to the patient at birth:

- | | | |
|--|--|---|
| <input type="checkbox"/> difficult delivery | <input type="checkbox"/> breech delivery | <input type="checkbox"/> shoulder dystocia |
| <input type="checkbox"/> long 2nd stage of labour | <input type="checkbox"/> forceps or suction used | <input type="checkbox"/> hip displacement |
| <input type="checkbox"/> jaundice | <input type="checkbox"/> vitamin K administered | <input type="checkbox"/> birth injuries |
| <input type="checkbox"/> problems with feeding | <input type="checkbox"/> antibiotic eye drops | <input type="checkbox"/> congenital abnormalities |
| <input type="checkbox"/> respiratory abnormalities | <input type="checkbox"/> medication | other: _____ |
| | <input type="checkbox"/> seizure | |

developmental history:

how would you describe the patient's health in the first year?

- poor fair good excellent unknown

please indicate the approximate age of the patient when the following developmental milestones were achieved:

weaned off breast milk _____ pulled up to stand alone _____ took first steps _____ spoke sentence _____

sat up alone _____ spoke first words _____ walked alone _____ dressed self _____

crawled _____ ate solid foods _____ fed self _____ toilet trained _____

please explain any developmental problems, if any: _____

is the patient particularly sensitive to any of the following?:

- small spaces heights crowds cold heat wind drafts
- sunlight wool music smells (please list): _____