

Patient Information (Child)

Please fill out this form to the best of your ability, it will help me to best address your child's health. If you need more space feel free to use the back of the page.

GENERAL INFO:

Child's Full Name _____ Age _____ Today's

Date _____

Child's Address _____

Home Phone Number (____) _____ Date of Birth (D/M/Y) _____ Place of Birth

Gender: M / F Religious Dietary

Restrictions _____

Mother's/Guardian's Full Name _____

Address _____

Home Phone Number (____) _____ Work Phone Number (____) _____

Father's/Guardian's Full Name _____

Address _____

Home Phone Number (____) _____ Work Phone Number (____) _____

Who does the child live with
primarily? _____

Who may information be released to? _____

Emergency contact (name, address, phone # and relationship)

Medical Doctor's name, address and phone #

Today's Chief Health Concerns:

1) _____

2) _____

3) _____

PREGNANCY:

Mother's health before pregnancy? Excellent good fair poor

Father's health before pregnancy? Excellent good fair poor

Mother's health during pregnancy? Excellent good fair

poor _____

Mother's typical diet while pregnant:

allergies/sensitivities:

Medications or nutritional supplements (vitamins) taken during pregnancy (include dose/frequency):

Any use of cigarettes, alcohol, recreational drugs (substance and frequency):

Any medical problems during pregnancy (circle): hypertension diabetes nausea/vomiting

STD's _____ vaginal bleeding candida trauma (physical/emotional)

other _____

DELIVERY:

How was the delivery in general?

weeks gestation _____ Length of labour _____ Location (e.g. hospital):

Were painkillers used? Type? _____

Maternal Complications (circle): induction C-section forceps suction episiotomy stitches

other _____

Fetal Complications (circle): jaundice cord around neck trauma asphyxiation infection

other _____

INFANCY:

Birth Weight _____ Length _____ APGAR score _____

General Health _____

Sleep Habits _____

Urine/Bowel Habits (constipation, diarrhea, etc.) _____

Nutrition: Formula (type) or breast milk? _____ If breast fed, how long? _____

When weaned? _____ How was the appetite? _____

Foods introduced and age: 0-6 months? _____

6-12 months? _____

Adverse reactions (colic, rash, vomiting, etc.)? _____

Developmental Milestones: At what age did the child do the following:

Held up head _____ Rolled over _____ Sat with support _____

Sat alone _____ Stood with support _____ Stood alone _____

Walked with support _____ Walked alone _____ First word _____

First sentence _____ Toilet trained _____ Tied shoes _____

Please rate the following compared to your child's peers:

Physical Development: below average average above average well above average

Mental Development: below average average above average well above average

Emotional Development: below average average above average well above average

CHILDHOOD

How is your child's health in general?

ILLNESSES (age, severity, frequency)

Chicken pox _____ Measles _____

Rubeola _____ Mumps _____

Recurrent Throat Infections _____ Recurrent Ear Infections _____

Other _____

TRAUMAS physical or emotional (circle)

broken bone stitches concussion bike/car accident animal bites sprains
allergic reactions death of loved one abuse (type) _____ other _____

HOSPITALIZATIONS/SURGERIES (example - tonsils, adenoids, etc.)

Date	Surgery	Complications

IMMUNIZATIONS

Vaccine	Date	Complications
MMR (measles, mumps, rubella)		
DTP (diphtheria, tetanus, pertussis)		
Small pox		
Hib (<i>H. influenzae</i> type b)		
Hepatitis B		
Polio		
Influenza ("the flu shot")		
Other		

ALLERGIES (circle)

Wheat Dairy Peanuts Other Foods _____

Penicillin Other Drugs _____

Dust Pollen Cigarette Smoke Pets Other _____

MEDICATIONS - Current and previous

Drug/Supplement	Date	Dose/Duration	Reason/Indication

DIET - Please provide a 24 hour diet recall of your child including drinks and snacks

Self image/self esteem	1	2	3	4	5	
Overall happiness		1	2	3	4	5
Stress level at home (5 being most stress)	1	2	3	4	5	

Describe your child's emotional environment

Would you describe you child as more optimistic (positive) or pessimistic (negative)?

How many hours per day does you child spend:

Watching TV _____ On the computer _____ Playing/physical activity

Extra-cirricular Activities	Time involved per week

Please list:

Your child's fears/anxieties: _____

Unusual

behaviours/habits: _____

Unusual sleep habits: _____

Is there anything you feel is important about your child's health that hasn't been covered?

Thank you for your time and patience with this form. I look forward to working with you to achieve optimal health for your child.