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Date: ___________________

Your Name: _____________________ Relationship to Child: ______________
Child's Name: _______________________Age: ___ Date Of Birth: ________

Child's Primary Residence:
Name: ___________________________ Relationship to Child: ______________
Address: ____
Phone: (Office): _______________________ (Home): _____________________

Alternate Residence/Contact:
Name: ___________________________ Relationship to Child: ______________
Address: ____
Phone: (Office): _______________________ (Home): _____________________

Referred By: ____

Health Concerns For Your Child:
1. _____________________________3. ___________________________________
2. _____________________________4. ___________________________________

Other Health Care Providers:
____
____
____

List Medications / Supplements Your Child Is Currently Taking (Include Dosage):

____

____

____

List Medications / Supplements Your Child Has Had In The Past:

____

____

Antibiotics? Yes No If Yes, How many Times? ______

List Any Major Illnesses or Injuries in Your Child's Life With Approximate Dates:

____

____

____

Any Medical Or Environmental Allergies or Sensitivities?

____

____

Circle Any of The Following That Your Child Has Had:

German Measles (Rubella) Roseola Impetigo
Measles Scarlet Fever Mononucleosis
Chicken Pox Mumps Ear Infections
Whooping Cough Strep Throat

Please Indicate what Immunizations Your Child Has Had:

- ❑ The Usual Vaccination Protocol - Recommended By Your Medical Doctor
- ❑ Only The Following (please indicate):
  - Pentacel (diptheria, pertussis, tetanus, polio, haemophilus)
  - NeisVac-C (meningococcal)
  - Prevnar (pneumococcal)
  - Recombivax (hepatitis B)
  - MMR2 (measles, mumps, rubella)
  - DPT (diphtheria, pertussis, tetanus)
  - Flu Shot
  - Varivax3 (chicken pox)
  - Tetanus Booster. When? _______________
- ❑ Others: _________________________________

Any Reactions To Immunizations? _______________________________________

____

Prenatal Health

- ❑ The Child Was **Adopted** At Age__________.
- ❑ Information About The Mother's Pregnancy And Birth Are Unknown.

Mother's Age At Child's Birth: _____

Please Circle Any Of The Following That Were Experienced By The Mother During Pregnancy:

Bleeding	High Blood Pressure	Diabetes
Nausea	Vomiting	Thyroid Problems
Physical Injury	Emotional Stress	Other? _______

Please Indicate Which Of The Following Were Used By The Mother During Pregnancy:

- ❑ Tobacco. Frequency: ____________ Alcohol. Frequency: __________
- ❑ Prescription Medication:_______________________________________
- ❑ Over-the-counter Medications:__________________________________
- ❑ Supplements (Herbs, Vitamins...):______________________________
- ❑ Any Other? ____

Birth History

Premature? ___________wks.		Late? _________wks.
Vaginal Birth	Epidural	Cesarian Section
Forceps	Induced	Other? ___________

Length Of Labour: _________ Weight at Birth: ____________

List Any Complications: _______________________________________

Please Indicate Any Of The Following Your Child Experienced Following Birth.

θ Jaundice θ Rashes θ Seizures

θ Birth Injuries: ____

θ Birth Defects: ____

Diet

θ Breastfed? _______Months.   θ Formula? Type: ________________

What Foods Were Introduced Before 1 year of age (In Order Of Introduction)?

____
____
____

Did Your Child React To Any Of The Foods Introduced? Please Also Mention Any Known Food Sensitivities or Allergies.

____
____
____

Describe A Typical Day's Diet:

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Drinks: ____

Family History

Please Indicate If A Close Relative Has Had Any Of The Following:

θ Allergies   θ Diabetes   θ Asthma
θ Eczema   θ Kidney Disease   θ Arthritis
θ Cancer   θ Heart Disease   θ Tuberculosis
θ Gonorrhoea   θ Malaria   θ Depression
θ Others? ____

Social and Environmental Health

At What Age Did Your Child First: Sit Up? _______
Crawl? ________
Walk? _________
Talk? _________

Describe Your Child's Sleep Patterns: ___________________________________
Describe Your Child's Temperament: ____________________________________
Describe Your Child's Behaviour And Performance At School: ______________
____
Where Does The Child Mostly Spend His/Her Time? ____________________
____
How Does Your Child Get Exercise? ___________________________________
____
How Much Television Does Your Child Watch? ___________________________
How Often Does Your Child Read or Get Read To? ______________________

Is Your Child Regularly Exposed To Tobacco Smoke? θ Yes θ No
Are There Animals In The Home? θ Yes θ No

How Would You Describe The Emotional Climate In Your Child's Home?
____
____