

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Who is filling out this form (name and relation)? _____

Contacts:

1. Name: _____ Phone: _____

Address: _____

Relationship to child: _____

2. Name: _____ Phone: _____

Address: _____

Relationship to child: _____

Who does the child live with?

Other health care providers (name and phone number):

1.

2.

3.

How did you hear about our clinic?

What are your child's health concerns, in order of importance:

1.

2.

3.

4.

5.

Medical History

How would you describe your child's general state of health?

Please indicate any serious conditions, illnesses, injuries or hospitalizations along with dates:

Please circle any of the following that your child has had:

Rubella (german measles)

Mumps

Whooping cough

Measles

Roseola

Strep throat

Chicken pox

Scarlet fever

Mononucleosis

Does your child have any allergies (medicines, environmental, food)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.):

Please list past prescription medications:

How many times has your child been treated with antibiotics?

Did your child receive routine childhood vaccinations?

Please indicate if any caused adverse reactions:

Prenatal Health

Describe the mother's health at conception:

Describe the father's health at conception:

Describe the mother's health during the pregnancy:

What was the mother's age at child's birth?

Describe the mother's diet during pregnancy:

Who provided prenatal care?

Circle any of the following which the mother experienced during pregnancy:

Bleeding

High blood pressure

Nausea

Physical or emotional trauma

Diabetes

Thyroid problems

Vomiting

Were any of the following used by the mother during pregnancy? If yes, indicate amount.

Tobacco:

Recreational drugs:

Alcohol:

Caffeine:

Prescription medications:

Over-the-counter medications:

Supplements/Vitamins:

Birth History

Length of pregnancy: _____wks

Length of labour:

Weight at birth:

List any interventions used during the birth (epidural, C-section, forceps, induction, etc.):

Were there any complications with the birth?

Circle any of the following that the child experienced shortly after the birth:

Jaundice Rashes Seizures

Birth injuries Birth defects Other:

Diet

How was your infant fed?

What foods were introduced first? Indicate approximate month of introduction.

Did your child ever experience colic? **Y N** How severe?

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions?

Health and Development

Describe your child's health in the first year:

At what age did your child first:

Sit up: Crawl: Walk: Talk:

Describe your child's sleep pattern:

How would you describe your child's temperament?

How would you describe your child's behaviour and performance in school?

Does your child exercise regularly? **Y N** What type and how often?

How much television does your child watch?

What are your child's favourite activities?

Environment

Does anyone in the child's household smoke?

Are there animals in the home?

Do you know of any toxins or other hazards the child is regularly exposed to? Please list:

How is the child's home heated?

Family History

Indicate if a close relative (parent, sibling) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other:	
Juvenile arthritis			

Do either of the parents have a chronic illness? **Y N** Please describe:

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

***Thank you for taking the time to complete this form.
I look forward to working with you and your child.***