Today's Date: _____

WHO IS FILLING OUT THIS FORM?

_____ _____
Name (Please print in block letters) Relationship to child

PATIENT INFORMATION

Name: _____ _____ _____
First name Middle name Last name

By what name does the child prefer to be called? _____

Date of Birth (MM/DD/YYYY): _____ Current Age: _____ Sex: _____

Address: _____ _____
Street address Apartment #

_____ _____ _____
City Postal code Province

Please provide your contact information below and indicate whether or not we may leave messages relating to the child's appointments:

		Message?			Message?
(H) phone			Cell		
(W) Phone			E-mail		

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to child: _____

Phone numbers: H: ( ) _____ OTHER: ( ) _____

HOW DID YOU HEAR ABOUT DR. BENNA LUN, ND?

☐ Website
☐ Passing by clinic
☐ Seeing another health practitioner in this clinic
☐ Referred by another patient
☐ Referred by clinic staff member
☐ Referred by health care provider
☐ Other (please specify: _____)

HEALTH CARE PROVIDERS **(continued on next page)**

Please list the other health care providers from whom the child currently receives treatment:

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

HEALTH CARE PROVIDERS (continued)

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

Does the child have regular screening tests with a doctor (e.g. yearly physicals, etc.)? Yes No

CHIEF CONCERNS

Please list the top health care concerns for which the child is seeking treatment in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL HISTORY

How is the child's general state of health? Excellent Good Average Fair Poor

Please list any past health concerns, including major illnesses, hospitalizations, surgeries, etc., with approximate dates:

- _____
- _____
- _____
- _____

Does the child have any allergies (medication, seasonal, environmental, etc.)? _____

_____

MEDICATIONS & SUPPLEMENTS

CURRENT prescription medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST prescription medications *(within the past 1-2 yrs or longer)*			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Over-the-counter (non-prescription medications) (e.g. for pain, allergies):

_____

_____

IMMUNIZATION HISTORY

Please indicate which immunizations the child has received:

- ☐ DPT (Diptheria, Pertussis, Tetanus)
- ☐ Polio
- ☐ Hemophilus influenza B
- ☐ Pneumococcal
- ☐ Rotavirus
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Meningococcal
- ☐ Varicella (chickenpox)
- ☐ Smallpox
- ☐ Rotavirus
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ "Flu" shot
- ☐ Tetanus booster – Date: _____
- ☐ Other: _____

Did any of the vaccines cause a negative reaction? Please describe: _____

_____

FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in the child's family. Include parents, siblings, grandparents, aunts, and uncles and specify maternal / paternal lineage.

Health condition	**Family member(s)**
Asthma	
Allergies (e.g. environmental, seasonal, food)	
Skin condition (e.g. eczema, psoriasis)	
Heart disease (e.g. heart attack, stroke, high blood pressure, high cholesterol)	
Diabetes	
Thyroid disease (Low or High functioning?)	
Joint condition (e.g. arthritis, rheumatism)	
Auto-immune disease (e.g. multiple sclerosis, lupus)	
Cancer (Please indicate type)	
Mental illness (e.g. anxiety, depression, schizophrenia)	
Other (please describe):	

☐ I don't know the child's family medical history

PRENATAL HEALTH HISTORY

What was the health of the child's mother during pregnancy? (Please circle)

Excellent Good Average Fair Poor Unknown

How old was the child's mother at the time of his/her birth? _____ years

Did the child's mother receive prenatal health care? (Please circle) Yes No Unknown

Did the child's mother experience any of the following during pregnancy? (Select all that apply)

- ☐ Nausea and/or vomiting
- ☐ High blood pressure
- ☐ Abnormal bleeding
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Physical trauma
- ☐ Emotional trauma
- ☐ Other: _____

Did the child's mother use any of the following during pregnancy: (Select all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Caffeine
- ☐ Recreational Drugs: _____
- ☐ Prescription medications: _____
- ☐ Over-the-counter medications: _____
- ☐ Herbal supplements: _____
- ☐ Other supplements: _____
- ☐ Other: _____

BIRTH HISTORY

Term length: _____ weeks Length of labour: _____ hours

Type of birth: ☐ Vaginal ☐ C-section ☐ Induced labour ☐ Forceps ☐ Use of anesthetics

Weight at birth: _____ (in kg or lbs) Length at birth: _____ (in cm or inches)

Birth complications? (Please describe) _____

_____

Did the child experience any of the following at or shortly after birth?

- ☐ Jaundice
- ☐ Rashes
- ☐ Seizures
- ☐ Birth defects: _____
- ☐ Birth injuries: _____
- ☐ Other: _____

HEALTH & DEVELOPMENT

How was the child's health in his/her 1st year? (Please circle) Excellent Good Average Fair Poor

How would you describe the child's current:

- Sleeping pattern? Any difficulties? _____

  _____

- Mood & Temperament?_____

  _____

- Behaviour at home? _____

  _____

- Behaviour and performance at school / daycare? _____

  _____

DIET

How was the child fed prior to 6 mths of age? _____

Please list examples of what the child typically consumes:

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

Beverages: _____

How are the child's meals usually prepared? (please circle) Home-made Purchased Both

Does the child have any food allergies, sensitivities, or intolerances (that you know of)? Yes No

Please describe: _____

_____

Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)? Yes No

Please describe: _____

LIFESTYLE

The child is currently in: (Select all that apply)

☐ Day care ☐ School: Grade _____ ☐ Other: _____

☐ Pre-school ☐ Home-school: Grade _____ _____

What is the child's activity level? (please circle) Inactive Mildly active Moderately active Active

What are the child's favourite activities? _____

_____

Roughly how much time (per day or per week) does the child spend doing the following activities:

TV: _____ Computer: _____ Video games: _____ Other electronic devices (e.g. cell phone): _____

LIVING ENVIRONMENT

Is the child exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through work, hobbies, home environment, etc.? (Please circle) Yes No

Please describe: _____

Is the child frequently exposed to animals (including pets)? (Please circle) Yes No

Please describe: _____

How would you describe the emotional environment in the child's household? _____

_____

_____

How stressful is the child's school / other aspects of his/her life? _____

_____

_____

How well do you feel the child handles stress? _____

_____

_____

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

_____

_____

Thank you for taking the time to complete this form