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:

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

## DIET

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: ____________________________________________________________

## HEALTH & DEVELOPMENT

How was the child's health in his/her childhood? Excellent Good Average Fair Poor

Has the child entered puberty? No Yes

If Yes: Any health changes occurring with puberty that are of concern? ______________________

____________________________________________________________

Describe the child's sleeping pattern / sleep difficulties: ________________________________________

________________________________________________________________________

How would you describe the child's temperament? ________________________________________

________________________________________________________________________

How would you describe the child's behaviour and performance at school? __________________________

________________________________________________________________________

________________________________________________________________________

## LIFESTYLE

The child is currently in: ☐ School: Grade _______ ☐ Other: ____________________________
☐ 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 electronics device (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 / work / 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*

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LiveWell Niagara, 6150 Valley Way, Unit 204, Niagara Falls, ON
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