



Please list any vitamins, minerals, herbal or homeopathic remedies she/he is currently taking and amounts/dosage: \_\_\_\_\_

Does he/she have any allergies or sensitivities? \_\_\_\_\_

How often does she/he have a bowel movement? \_\_\_\_\_

Does he/she strain to have a bowel movement? \_\_\_\_\_

Related to particular food or circumstance? \_\_\_\_\_

Does she/he have loose bowel movements? Yes \_\_\_ No \_\_\_ Occasionally \_\_\_

Related to particular food or circumstance? \_\_\_\_\_

### **Immunizations:**

\_\_\_ Measles                    \_\_\_ DTaP                    \_\_\_ Hepatitis B

\_\_\_ Mumps                    \_\_\_ Hib                    \_\_\_ Hepatitis A

\_\_\_ Rubella                    \_\_\_ IPV (polio). \_\_\_ Rotavirus

\_\_\_ Chicken Pox            \_\_\_ Influenza

Any reactions? \_\_\_\_\_

Please check any of the below that relates to your child.

\_\_\_ Frequent colds                    \_\_\_ Measles

\_\_\_ Ear infections                    \_\_\_ Mumps

\_\_\_ Tonsillitis                    \_\_\_ Rubella

\_\_\_ Rheumatic fever                    \_\_\_ Scarlet fever

\_\_\_ Chicken pox                    \_\_\_ Pneumonia

Others: (please list) \_\_\_\_\_

### **Symptoms:**

(mark **C** for current and **P** for past symptoms)

- |                       |                        |                        |
|-----------------------|------------------------|------------------------|
| ___ Hives             | ___ Talks in sleep     | ___ Vomiting spells    |
| ___ Eczema            | ___ Bruises easily     | ___ Bleeding gums      |
| ___ Chronic rash      | ___ Dizzy spells       | ___ Jaundice           |
| ___ Hair loss         | ___ Cough              | ___ Nosebleeds         |
| ___ Excessive fatigue | ___ Wheezing           | ___ Nervous            |
| ___ Bed wetting       | ___ Anemia             | ___ Sensitive to light |
| ___ Sore throats      | ___ High fevers        | ___ Bad breath         |
| ___ Frequent colds    | ___ Blood in urine     | ___ Body odour         |
| ___ Canker sores      | ___ Stomach aches      | ___ Motion sickness    |
| ___ Burning urination | ___ Constipation       | ___ Freq. headaches    |
| ___ Cries easily      | ___ Diarrhea           | ___ Joint pains        |
| ___ Sleep problems    | ___ Gas                | ___ Flat feet          |
| ___ Nightmares        | ___ Change in appetite | ___ Hearing loss       |
| ___ Night sweats      | ___ No appetite        | ___ Heart murmur       |
| ___ Walks in sleep    |                        |                        |

**Mother's health during pregnancy:**

(check all that apply)

- Bleeding
- Nausea
- Physical or emotional trauma
- Cigarettes, alcohol, drugs
- Illnesses
- Diabetes
- Hypertension
- Thyroid problems
- Medications

**Term:**

Full  Premature  Late

Birth weight: \_\_\_\_\_

What kind of delivery:  vaginal  caesarean  forced vaginal birth

How long was the labour? \_\_\_\_\_ Did it go well? \_\_\_\_\_

Has your child had any of the following problems:

- Jaundice
- Diarrhea
- Colic

**Family History**

**Hereditary Diseases:**

Use **F** for father, **M** for mother, **S** for sibling, **G** for grandparent, **O** for others

- Heart disease
- Hypertension
- Intestinal Disease
- Asthma
- Kidney Dysfunction
- Diabetes
- Arthritis
- Osteoporosis
- Ulcers
- Cancer, type: \_\_\_\_\_
- Allergies
- Mental Illness
- Alcoholism
- Gall Bladder problems

**Dietary Habits:**

How many times a day does she/he eat:

Main meals  Times of day: \_\_\_\_\_

Snacks  Times of day: \_\_\_\_\_

Does he/she eat meals: with family  home alone  on the run   
in a restaurant

Are there any restrictions to her/his diet due to preferences of others?

Yes  No If yes, explain

\_\_\_\_\_  
\_\_\_\_\_

How many 1/2 cup servings of each does he/she typically eat in a day:

- Fruit: Fresh  Dried  Canned
- Vegetables:  Cooked  Raw
- Whole grains
- Protein: Type \_\_\_\_\_
- Dairy Products: Type \_\_\_\_\_
- Others: Specify \_\_\_\_\_

Give examples of his/her typical meals:

Breakfast:

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Lunch:

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Dinner:

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Snacks:

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Does she/he eat or use: (indicate 1 for rarely, 2 for regularly, 3 for often)

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> aluminum pans | <input type="checkbox"/> margarine   | <input type="checkbox"/> candy                 |
| <input type="checkbox"/> microwave     | <input type="checkbox"/> fried foods | <input type="checkbox"/> processed foods       |
| <input type="checkbox"/> cold meats    | <input type="checkbox"/> fast foods  | <input type="checkbox"/> Nutra-Sweet/Aspartame |

Please indicate how many cups of the following he/she drinks per day:

- |   |  |
|---|--|
| <input type="checkbox"/> tap water              | <input type="checkbox"/> fruit juices (bottled)          |
| <input type="checkbox"/> bottle or spring water | <input type="checkbox"/> fresh fruit or vegetable juices |
| <input type="checkbox"/> soft drinks            | <input type="checkbox"/> herbal tea                      |
| <input type="checkbox"/> milk (whole)           | <input type="checkbox"/> other _____                     |
| <input type="checkbox"/> milk (skim 1%,2%)      |  |

Is he/she a  meat eater  vegetarian  vegan

How often does she/he eat meat?  daily  3-5/week  
 once/week or less

How often does he/she consume dairy products?

daily  3-5/week  once/week or less

What are his/her favourite foods?

How often does she/he eat them? \_\_\_\_\_

Does she/he experience any symptoms after meals? Explain:

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Comments:

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**Client Statement:**

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (Mobile) \_\_\_\_\_

*\*All information contained on this form will be kept strictly confidential*