Please fill out the following form in as much detail as possible to help us best understand your needs and health concerns. All information shared is strictly confidential.

PATIENT INFORMATION		
Name:_____ (First)	_____ (Middle)	_____ (Last)
Date of Birth: (mm/dd/yy)	Age:	Sex: ☐M ☐F ☐ Other_____
Parent name: _____ Parent name: _____		

CONTACT INFORMATION		
Home Address:		
City:		Postal Code:
Home Phone:	Parent Cell Phone:	Parent Work Phone:
May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. ☐Home ☐Cell ☐Work		
Parent Email address:		
Would you like to receive our newsletter for news, events and special offers? ☐Yes ☐No	Preferred method of contact: ☐Phone ☐Email	

EMERGENCY CONTACT INFORMATION
Primary Contact:
Relationship:
Phone number(s) for emergency contact:

OTHER HEALTHCARE PROVIDERS		
Medical Doctor:	Location and phone number:	Date of last visit:
Other Practitioner/Specialist:	Location and phone number:	Date of last visit:

CLINIC INFORMATION

How did you hear about the clinic?

Were you referred to Dr. Anousha? If so, who referred you?

Have you been to a naturopathic doctor before? ☐Yes ☐No

HEALTH CONCERNS

What are your most important health concerns? Please list them in order of importance

- _____
- _____
- _____
- _____
- _____
- _____

Does your child have any known contagious diseases at this time? ☐Yes ☐No
If yes, please provide details.

IMMUNIZATIONS

Please check (√) any immunizations the patient as received:

☐MMR ☐Influenza ☐ Other (please specify)_____

☐DPT ☐Smallpox ☐ Decided not to vaccinate

☐Polio ☐Chickenpox Are immunizations up to date? ☐Yes ☐No

MEDICATION AND SUPPLEMENTS

Please list any prescription medications, over the counter medications, vitamins, or other supplements your child is taking **with dosages and frequency:**

Dose **Frequency**

- _____
- _____
- _____
- _____
- _____

Can your child swallow pills? ☐Yes ☐No

Is your child currently taking, or has taken in the past (please check (√) and *circle*):

☐Yes ☐ No Aspirin (*current past)*

☐Yes ☐No Tylenol (*current past)*

☐Yes ☐No Ibuprofen (Advil) (*current past)*

☐Yes ☐No Antibiotics *(current past)*

Number of Antibiotic prescriptions _____

ALLERGIES & SENSITIVITIES (PLEASE LIST)

_____ _____ _____

_____ _____ _____

_____ _____ _____

CONTEXT OF CARE

What 3 health goals do you have while under the care of Dr. Anousha?

- _____
- _____
- _____

GENERAL INFORMATION

Height: _____ Weight:_____ Weight one year ago: _____	Please indicate level of satisfaction on a scale of 0-10, 10 being the most satisfied Sleep Energy Mood	Does your child perform any regular physical exercise? ☐ Yes ☐ No If so, how many hours?	Indicate how many hours your child sleeps each night: Does your wake feeling rested: ☐Yes ☐No

BRIEF MEDICAL HISTORY

Has your child ever had any of the following?

Electroencephalogram (EEG): ☐Yes ☐No Sleep study: ☐Yes ☐ No

Psychological evaluation: ☐Yes ☐No Hearing tests: ☐ Yes ☐No

Speech/Language evaluation: ☐Yes ☐No Vision tests: ☐ Yes ☐ No

Injuries, surgeries or hospitalizations (please specify): ☐ Yes ☐No

Has your child experienced any of the following (please *circle*):

Constipation (*current past*) Diarrhea (*current past*) Vomiting (*current past*) Stomach aches (*current past*) No appetite (*current past*) Excessive thirst (*current past*) Joint pain (*current past*) Light sensitivity (*current past*) Sound sensitivity (*current past*) Seizures (*current past*) Excessive urination (*current past*)	High fevers (*current past*) Sore throat (*current past*) Chronic rash (*current past*) Hives (*current past*) Eczema (*current past*) Cough (*current past*) Wheezing (*current past*) Frequent colds/flu (*current past*)	Nose bleeds (*current past*) Anemia (*current past*) Heart murmur (*current past*) Hearing loss (*current past*) Excessive fatigue (*current past*) Excessive energy (*current past*) Sleep problems (*current past*) Nightmares (*current past*) Night sweats (*current past*) Easy bruising/bleeding (*current past*)

FAMILY HISTORY

Family Member Age Illness

- _____ _____ _____
- _____ _____ _____
- _____ _____ _____
- _____ _____ _____
- _____ _____ _____
- _____ _____ _____

PRENATAL/MATERNAL HEALTH HISTORY

Previous pregnancies by birth mother, miscarriages, or complications? Yes No

Please indicate if any of the following were experienced by birth mother during pregnancy:

- Bleeding ☐Yes ☐ No - Physical or emotional trauma ☐Yes ☐No
- Illness ☐Yes ☐No - Cigarettes, alcohol, or drug consumption ☐Yes ☐No
- Medications ☐Yes ☐No - Diabetes ☐Yes ☐No
- Nausea ☐Yes ☐No - Other ☐Yes ☐No Please Indicate:
- Hypertension ☐Yes ☐ No

BIRTH HISTORY

Please indicate:

Full term ☐Yes ☐No Weight at birth_____ Any complications:

Premature ☐Yes ☐No

Late ☐Yes ☐No Mother's age at birth_____

Vaginal Delivery ☐Yes ☐No

C-section ☐Yes ☐ No Length of labour_____

Did your child have any of the following problems shortly after birth?

Rashes ☐Yes ☐ No Birth defects ☐Yes ☐No Other:

Jaundice ☐Yes ☐No Seizures ☐Yes ☐No

Colic ☐Yes ☐No Fever ☐Yes ☐No

Birth injuries ☐Yes ☐No Blue baby ☐Yes ☐ No

Was your baby breast fed? ☐Yes ☐No Breast fed for how long?_____

Was your baby formula fed? ☐Yes ☐No Type of formula (milk, soy):_____

What age did your child begin eating solids?_____ Which foods?_____

Age began: Sitting _____ Crawling_____ Walking_____ Talking_____