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NEW PATIENT CHILD QUESTIONNAIRE

LAST NAME: _____ INITIAL _____

FIRST NAME: _____

ADDRESS: _____ CITY _____ POSTAL CODE _____

EMAIL: _____

PARENT-GUARDIAN LEGAL NAME: _____

EMERGENCY CONTACT: _____

PHONE: _____ EMAIL: _____

DATE OF BIRTH: (D) _____ (M) _____ (Y) _____ AGE: _____

HEIGHT: _____ WEIGHT: _____

HOW DID YOU HEAR ABOUT THIS CLINIC? _____

CARE CARD NUMBER: _____

1. MAIN REASON(S) FOR ATTENDING THE CLINIC, IN ORDER OF IMPORTANCE. INDICATE WHEN THE SYMPTOMS HAVE APPEARED.

2. MEDICAL DOCTOR'S NAME: _____

3. DO YOU CONSULT OTHER HEALTH CARE PROFESSIONAL? PLEASE LIST:

4. PLEASE LIST DRUGS/MEDICATIONS CURRENTLY TAKEN:

5. PLEASE LIST DRUGS/MEDICATIONS TAKEN IN THE PAST:

6. PLEASE LIST ALL THE SUPPLEMENTS (VITAMINS, MINERALS ETC.) TAKEN:

7. WHICH OF THE FOLLOWING CONDITIONS HAS YOUR CHILD HAVE? (PLEASE CIRCLE)

ABCESSES/ALLERGIES/ANEMIA/ARTHRITIS/ASTHMA/CANCER/CHICKEN POX₁COLD SORES/DIABETES
EPILEPSY/HAY FEVER/HEART DISEASE/HEPATITIS/HERPES/INFLUENZA/KIDNEY DISEASE/LEUKEMIA
MALARIA/MEASLES/MONONUCLEOSIS/MUMPS/PARASITES/PLEURISY/PNEUMONIA/RECURRENT INFECTIONS
RHEUMATIC FEVER/RUBELLA/SCARLET FEVER/SKIN DISEASE/STREP THROAT/SINUSITIS/SUNSTROKE
TONSILITIS/WARTS/WHOOPING COUGH/WORMS

8. HAS THE CHILD HAD ANY OTHER MAJOR CONDITION?

9. ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH THE CHILD HAS NEVER BEEN TOTALLY WELL SINCE OR WHICH HAVE BEEN MORE SERIOUS THAN USUAL?

10. PLEASE LIST ALL THE SURGERIES AND WHEN PERFORMED:

11. WHAT VACCINATIONS HAS YOUR CHILD HAD? ANY ADVERSE EFFECTS FROM THEM?

12. INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR COMPLAINTS HAVE AFFECTED THE FAMILY MEMBERS.

INDICATE: F=FATHER, M=MOTHER, S₁=SIBLING 1, S₂=SIBLING 2 ETC., PGM=PATERNAL GRAND-MOTHER
MGM=MATERNAL GRAND-MOTHER, PA=PATERNAL AUNT, PU=PATERNAL UNCLE ETC...

ALCOHOLISM___ ALLERGIES___ ARTHRITIS___ ASTHMA___ CANCER___ DEPRESSION___
DIABETES___ EPILEPSY___ GONORRHEA___ GOUT___ HAYFEVER___ HEART DISEASE___ MENTAL
ILLNESS___ PARALYSIS___ PNEUMONIA___ SKIN DISEASE___ SYPHILIS___ TUBERCULINUM___

