



CHILD UNDER 12 YEARS

Client Name: _____ **Date:** _____
Age: _____ Date of birth: _____
Address: _____

Parent/Guardian name: _____ Phone: _____
Email: _____
Doctor: _____ Health fund: _____
What brings you into the clinic today? _____

What are your top health concerns, for the above named child, in order of importance? _____

General state of health is: (Please check)

Excellent Good Fair Poor

Date of last physical check with Doctor/Nurse: _____
Current medications (including supplements, vitamins, and herbs): _____

Allergies (drugs, food, chemicals, etc.): _____

MEDICAL HISTORY: (Please tick)

Chicken pox Tonsillitis Middle ear infections Eczema Asthma

Is there any history of repeated illnesses? Yes / No
If yes, please specify: _____

Past operations? Yes / No
If yes, please specify: _____

IMMUNIZATION HISTORY: (Please tick)

No vaccines Partly vaccinated Fully vaccinated

Continues over

Any further information? _____

FAMILY HEALTH HISTORY:

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

MOTHER'S PREGNANCY AND CHILD'S BIRTH: _____

Breast fed: Yes / No Aged stopped? _____ Solids started: _____

FOOD ALLERGIES/SENSITIVITIES: _____

Describe child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Weekend Diet if different: _____

SLEEP SCHEDULE: _____

Any problems getting to/ staying asleep? _____

Goes to bed at: _____ Asleep by? _____ Awakes at: _____ Awakes rested? _____

Are there any concerns regarding growth? _____

Are there any concerns for learning disabilities? _____

Please list any other concerns/health information here: _____

Signature: _____
