THE ALLERGY CENTRE HEALTH FOODS & CLINIC

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 mediations (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)

Continues over

No vaccines Partly vaccinated Fully vaccinated

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: _____