



Which of the following have you experienced? And indicate "C" (current) or "P" (past) or "F" (frequent):

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Ear infections                           | <input type="checkbox"/> Eczema/ Skin problems   | <input type="checkbox"/> Digestive problems     | <input type="checkbox"/> Growing pains / Scoliosis     |
| <input type="checkbox"/> Tonsillitis                              | <input type="checkbox"/> Allergies               | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Pneumonia                                | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Constipation/ Diarrhea | <input type="checkbox"/> Attention Problems - ADD/ADHD |
| <input type="checkbox"/> Sinus troubles                           | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Nausea/ Vomiting       | <input type="checkbox"/> Bed Wetting                   |
| <input type="checkbox"/> Chicken pox                              | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Roseola                | <input type="checkbox"/> Measles                       |
| <input type="checkbox"/> Bronchitis/ Upper Respiratory Infections | <input type="checkbox"/> Other (please specify): |   |  |

Has you ever been hospitalized (other than at birth)?

Date	Reason

Please list present and past medications, along with reason:

Medication	When?	Reason?

Approximate number of doses of antibiotics you have taken:

Please list any herbal or vitamin supplements you take:

Have you been vaccinated? Yes No  
If yes, which ones?

Were there any reactions observed? Please explain:

Do you exercise? Yes No

What type of exercise?

**Prenatal History:**

Were you premature?	Yes, # weeks:	No
Ultrasounds during pregnancy?	Yes, number:	No
Medications during pregnancy?		
Medications during labour/ delivery?		
What type of delivery did you have?		
Any complications during delivery?		
Location of birth:		
<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth centre	<input type="checkbox"/> Home
Child's weight at birth:		
Child's height at birth:		
Were you breastfed?	Yes, _____ months.	No
Or formula fed?	Yes; Type: _____.	
Introduced to solid foods at _____ months.		
Cow's milk at _____ months.		

**Family History:**

Relative	Living (age)	Health problems	Died (age)	Cause
Mother				
Father				
Siblings (List):				
Grandmother (Mom's mom)				
Grandfather (Mom's dad)				
Grandmother (Dad's mom)				
Grandfather (Dad's dad)				
Other - specify (aunts, uncles, etc)				

List any known allergies: (Include foods, medications, environmental, animals, etc.)

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Have you ever traveled abroad?	Yes	No
Location	Age at time of travel	

**School History:**

Current grade:
School contact: _____ number: _____
How many schools have you attended?
Have you ever dropped out of school?
Average grades:
Specific learning disabilities:
What have teachers/ principals/ guidance counselors said about you?
Do you enjoy school?      Yes                      No
Do you enjoy learning?              Yes                      No
Do you find school challenging?      Yes                      No
Do you participate in extra-curricular activities:      Yes                      No
Please list your hobbies/ sports:
What is your perceived stress level? (1 is not stressed, 10 is very stressed) _____.
What causes stress for you?

**Sexual History:**

At what age did you first notice signs of sexual development (underarm or pubic hair, breast development (females), "wet dreams" (males)?)
Do you currently believe yourself to be:
Homosexual                              Heterosexual                              Bisexual
Have you ever questioned your sexual identity?      Yes                      No
Are you sexually active?      Yes - currently      Yes - past      No
At what age did you become sexually active?
How many partners have you had?
Have you ever tested positive for a sexually transmitted disease?      Yes                      No
If yes, please explain:
Have you ever suffered from physical or sexual abuse?      Yes                      No

**Behavior History:**

Do, or have you ever engaged in any of the following? "N" (never), "S" (seldom), "F"(frequently)

<input type="checkbox"/> Lying/ stealing	<input type="checkbox"/> Rule breaking	<input type="checkbox"/> Self-abuse
<input type="checkbox"/> Starvation	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Violent behavior
<input type="checkbox"/> Bullying	<input type="checkbox"/> Vandalism	<input type="checkbox"/> Drug use
<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Cigarette smoking	<input type="checkbox"/> Other:

Do you have your driver's license? Yes No

Do you ever drive under the influence of alcohol? Yes No

Are you frequently a passenger in a vehicle where the driver has been under the influence of alcohol? Yes No

**FOR FEMALES:**

**Menstrual History:**

Have you started menstruating? Yes No

At what age did you begin menstruating?

How long is your cycle? \_\_\_\_\_ days. (count the number of days between the first day of your period and the first day of the next one)

How many days does your period last? \_\_\_\_\_ days.

Do you experience any associated symptoms?

<input type="checkbox"/> Bloating	<input type="checkbox"/> Cramps	<input type="checkbox"/> Nausea/ vomiting	<input type="checkbox"/> Food cravings
<input type="checkbox"/> Back pain	<input type="checkbox"/> Appetite changes	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Changes in bowel habits
<input type="checkbox"/> Other symptoms:			

**Additional comments:**

*Thank you! It's time for your healing journey to begin...*