Please bring the completed form to your first visit. Thank you.

Name	
Parents' names	
Address	
Parents' email	Parent's mobile ph
Parent's home ph	Parent's work ph
Date of birth	No. of siblings
GP / family doctor	

Main health problem? ______________________________

When did this first begin? ______________________________

How has this been treated until now? ______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Please list all medication / supplements your child is currently taking: ______________________________

____

(Please circle) Did your child ever need to take antibiotics, steroids, use an asthma inhaler?

Pre/perinatal: Mother's experience of pregnancy (physical, emotional), any birth complications?

____

Vaccinations: Which ones at what age, and were there any complications? ______________________________

____

Accidents? ______________________________

Surgeries? ______________________________

Diseases? ______________________________

Allergies? ______________________________

Is your child on a special diet? Vegetarian, vegan, gluten free, dairy free, other: ______________________________

Family's medical history (diseases of siblings, parents, and grandparents): ______________________________

____

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