Dr's Shaun & Lana Patterson
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New Patient Health Profile (Child 6-12)

Today's Date (M/D/Y): _____

Last Name: _____ First Name: _____

Parent/Guardian Name(s): (Mom) _____ (Dad) _____

Date of Birth (M/D/Y): _____ Age: _____ Gender: O M O F O Other

Home #: _____ Cell #: _____

Address: _____ City & Postal Code: _____

Email Address: _____

Who can we thank for sending you to our office? _____

PRIMARY CONCERN/COMPLAINT(S): _____

When did it start? _____ Frequency of Symptoms: _____

Intensity of Pain: *(no pain)* 0 1 2 3 4 5 6 7 8 9 10 *(extreme pain)*

Have you received any previous treatments for this complaint? O Yes O No *If yes, please see below:*

O Acupuncture O Physio O Massage O Other: _____

HEALTH HISTORY

Has your child ever suffered from the following?

O Asthma/Allergies O Headaches O ADHD O Digestive Problems O Temper Tantrums

O Other: _____

Rate your child's quality of sleep: O Excellent O Good O Ok O Poor O Terrible

List your child's food allergies or intolerances: _____

List your child's medications and/or supplements: _____

Rate the quality of your child's eating habits: O Excellent O Good O Ok O Poor O Terrible

Does your child have normal bowel movements daily? O Yes O No

Has your child had any major falls, injuries or motor vehicle accidents? O Yes O No *If yes, please explain below:*

_____

Does your child have any genetic disorders or disabilities? O Yes O No *If yes, please list below:*

_____

What activities is your child involved in? _____