Healthy Path Inc.

44 Marr Road
Rothesay, NB
E2E 3K6
506-847-0254

Child's Name:____Date:______________________
Parent/Guardian Name:_____________________________________
Address:___________________________________ City:______________________________
Province:___________________________________ Postal Code:______________________
Telephone:(H)___________________(W)_________________(C)____________________
Email:____
Birth Date:_________________________________ Occupation:______________________
Family Physician:____________________________

How did you hear about Healthy Path Inc?____

Has your child ever had allergy testing done? Yes_______ No_____
Does your child have any known allergies? Yes_______ No_____

If yes, list the allergies and reactions ____
____

Has your child ever had an anaphylactic reaction to anything? Yes________ No________
Has your child ever been on antibiotics more than twice a year? Yes_______ No________

Health Insurance: _______________ Policy #: ___________ ID#: _________________

Current medications/herbs/vitamins:

Medication name	Reason	Dose
____________________________	___________________________	______
____________________________	___________________________	______
____________________________	___________________________	______
____________________________	___________________________	______

Family history: (allergic tendency is not always inherited directly from the parents. It may skip generations or be manifested in nieces or nephews rather than in direct descendants)

Is there anyone with allergy symptoms in your family?

If so, what? How are they related to your child?
____
____

Is your child or any relatives unable to eat certain foods?
____
____

Indicate any and all medical conditions (I.e. Asthma, Eczema, ADD, ADHD, Autism, etc…)
____
____
____

List major surgeries/injuries/treatments that apply to your child and date it occurred:
____
____
____

Check any events immediately preceding and/or following your child's first allergic reaction:

___Did he/she change your diet or go on a special diet?
___Did he/she eat something new that they haven't eaten for two or three months?
___Did he/she eat one food repeatedly, every day for a few days?
___Did symptoms first appear after a major operation?
___Did symptoms first appear at adolescence or after having a baby?
___Did symptoms appear after an automobile accident or any major physical or emotional trauma?
___Did symptoms appear after a lengthy exposure to the sun?

Current Symptom Checklist (Rate intensity of symptoms currently present)

Mild=Impacts quality of life, but no significant impairment of day-to-day functioning. **Moderate**=Significant impact on quality of life and/or day-to-day functioning. **Severe**=Profound impact on quality of life and/or day-to-day functioning

Symptom:	Mild	Moderate	Severe	Symptom:	Mild	Moderate	Severe
Abusive behaviour/Hostile	( )	( )	( )	Frequent bedwetting	( )	( )	( )
Adolescent acne	( )	( )	( )	Growing pains	( )	( )	( )
Anxiety	( )	( )	( )	Headaches	( )	( )	( )
Bladder infections/Cystitis	( )	( )	( )	Hives, itching	( )	( )	( )
Bowel problems-diarrhea/constipation	( )	( )	( )	Inability to concentrate and learn	( )	( )	( )
Car sickness	( )	( )	( )	Insecurity/Introverted	( )	( )	( )
Chronic bad breath	( )	( )	( )	Irritable/Mood swings	( )	( )	( )
Chronic colds that don't clear	( )	( )	( )	Leg wiggling/restlessness	( )	( )	( )
Chronic ear infections	( )	( )	( )	Mouth breathing	( )	( )	( )
Clumsiness	( )	( )	( )	Nasal congestion/runny/stuffy	( )	( )	( )
Coated tongue	( )	( )	( )	Night wakefulness/Insomnia	( )	( )	( )
Colic, excessive spitting up in infancy	( )	( )	( )	Nose bleeds	( )	( )	( )
Dark circles/wrinkles under eyes	( )	( )	( )	Overactive/Hyperactive	( )	( )	( )
Depression/Tearfulness	( )	( )	( )	Overweight	( )	( )	( )
Dyslexia	( )	( )	( )	Pale face	( )	( )	( )
Ear redness	( )	( )	( )	Persistent cough, bronchitis	( )	( )	( )
Excessive drooling in infancy	( )	( )	( )	Picky or Binge eater	( )	( )	( )
Fatigue or laziness	( )	( )	( )	Red, rough skin patches	( )	( )	( )
Flushed	( )	( )	( )	Tonsilitis/Repeated strep throat	( )	( )	( )

Is there any other information we need to know?
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