



**A New Leaf
Naturopathic Clinic**

Children's Confidential Patient Health Record

Name _____ Age _____

Birth date ___/___/___
Month/Day/Year

Address _____ City _____

Postal Code _____

Parent/Guardian:

Name: _____

(Please check the phone number you would like the clinic to contact you at)

Home Phone: _____

Business Phone: _____

Cell Phone: _____

Email Address _____

MD Physician _____

Phone: _____

Person to notify in an emergency _____

Phone: _____

Do you have extended medical? **Y / N**

Is this a referral? **Y / N**

How did you hear about the clinic?

Naturopathic Medicine Informed consent for treatment

I _____ hereby authorize A New Leaf Naturopathic Clinic to perform specific procedures on my child as deemed necessary to facilitate my diagnosis and treatment.

Parent /Guardian Signature _____

Date: _____

Current Health Condition

What health concerns brought you to the office today?

Please List all medications presently taking

If you take supplements, please list brand, dosage and reason for taking the supplement.

Personal Health Habits

Height: _____ Current Weight: _____ lbs

Diet: Is there any foods that you avoid? _____

Vaccination History:

Vaccination	Age	Vaccination	Age	other
Diphtheria		MMR		
Whooping cough		Hepatitis A/B		
Tetanus		Hemophilus Influenza B		

Was the Patient breastfed? Y/N For how long? _____

How Many hours do you sleep/night? _____ During the Day? _____

Personal Health History

Please list all surgeries that you have had, dates and reasons.

How many times a year do you get a cold or flu?

Please list all allergies (*food and environmental*)

Explain your dental health (*any fillings/Dental Visits*) _____

I understand that 24 HOURS NOTICE IS REQUIRED FOR ALL CANCELLATIONS including visits, injections, IVs, and labs and that I will be charged for missed appointments where I have not given due notice. _____(INITIAL)