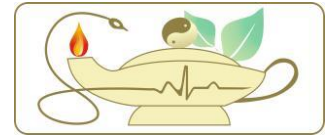


2020

Naturopathic and Allergy Clinic

Telephone (416) 207-0207, fax (416) 207-0272

Email:clinic@live.com



Confidential Child's Case History (to be completed before your visit in INK only please)

Version jan 2020

Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND**, to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help restore your child's health. We will only accept your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④ diet as given to treat your child. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark (*), Thank you.**

Child's information

*Last name: _____ *First name: _____ Middle name: _____
 *Date of birth: MM. DD. YY. Sex: Male, Female, Height: _____ Weight: _____ Last physical date: _____
 *Child has been unwell for: _____ Yrs., Physician's name who treated my child as: _____
 My child was treated by a Medical Dr., Chiropractor, Naturopath Dr., Psychiatrist, Hospital, Homeopath, Herbs.
 Was treatment terminated? : Yes, No, Did treatment achieve its goal % (explain): _____
 * My child was treated for: _____
 * My child is currently suffering from and needs treatment for: _____
 Family members who have similar conditions: Mother, Father, Brother(s), Sister(s), Daughter(s), Son(s), Adopted.
 Number of older brothers: _____ Number of older sisters: _____ Child's rank in the family is: _____
 Number of younger brothers: _____ Number of younger sisters: _____ Child's favorite sport is: _____
 *Child's home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____
 Child lives: With Both Parents, With Father, With Mother, Alternates Between Parents, With Relatives, Foster Home.

Father's Information

Last name: _____ First name: _____ Father's occupation: _____ Age: _____
 Home address: † Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____
 Home telephone (): _____ Office telephone (): _____ Ext. _____
 Cellular number (): _____ email: _____ @ _____

Mother's Information

Last name: _____ First name: _____ Mother's occupation: _____ Age: _____
 Home address: † Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____
 Home telephone (): _____ Office telephone (): _____ Ext. _____
 Cellular number (): _____ email: _____ @ _____

In case of an emergency who may we contact

*First name: _____ *Last name: _____ *Relationship: _____
 Telephone (H): () _____ (W): () _____ Ext. _____ Fax: () _____
 Do one or both parents have an extended health insurance at work Yes, No.? Name of Insurance company: _____

Do we have your permission to email you information and updates concerning your health plus seasonal promotions Yes , No

*Who referred you to this Clinic : _____
 Office sign, Currently a patient, Word of mouth, Surfing the Net, Office Pamphlet, TV Interview

Dear Parents / Guardians:

The following several pages contain questions concerning your child's health. There are some questions concerning both parents which pertain to your child's total health. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, You (or both parents) will be informed about some food restrictions that Dr. Srajeldin wants you to observe in your child's diet. You are expected to apply the diet as given to help your child recover from the current ailment. Additionally, your child's daily remedies, frequency and therapies will be set too.

Please note that naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). Naturopathic examinations, treatments and therapies for your child, could be covered by you're your child's school under extended health insurance or could be covered under extended health insurance plan at your place of employment or your spouse's place of employment if any of you have one. You may consult with your insurance company directly.

We do not deal directly with insurance companies and we have no Information about their coverage. We do not deal directly with insurance companies and we have no Information about their coverage.

Privacy: All your child's files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mails, emails, phone calls or leaving phone messages, then please give us written instructions here:

Continue on page (2) please

Parents' or Guardians' Declaration & Consent to Child Examination and Treatment

Child's Name (please print) _____ Date: _____

Assessment and Treatment

I understand that the clinics Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. Initial patients' visit to see the naturopath will include discussing your medical history from birth to date, standard physical examination, evaluation of your child's diet and prescribing remedies based on your child's medical history, physical examination, current symptoms and the results of your child's blood works (if available). Further, I understand that testing with traditional blood work and functional testing may be requested. I understand that the treatments can include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical medicine and Homeopathic medicine, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.

I understand that the clinic's mission statement is "*a Naturopathic Doctor is to provide safe and effective treatments to restore health permanently in the quickest, gentlest, least harmful way.*"

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are not covered by OHIP. I also understand that Naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). I understand that my child's Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). I understand that it is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.

I understand that any treatment provided to my child as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or any advice that I may be receiving or may in the future be receiving from another licensed health care provider. I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies. Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.

I understand that the total interview and the actual examination may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my child's diet thereafter. I will apply the diet as given. Along with the diet, my child's daily remedies, frequency and therapies will be set too.

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to reach Naturopathic Doctor.

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to reach Naturopathic Doctor.

This is to acknowledge that I have read the above information and understand that these are the terms and conditions at the Naturopathic and Allergy Clinic. I also consent to the examination of my child as been described above and as the examining naturopath sees necessary to help my child overcome his/her symptoms.

I will provide a copy of my child's most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all my child's medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to his/her health from his/her physician's office or the hospital if he/she was treated at a hospital.

I will answer the questionnaire concerning my child's health to the best of my ability and knowledge. I will pay for all my child's examinations, treatments, therapies and intravenous therapy immediately when rendered.

I understand that remedies and laboratory blood works are not included in the examination fee. I understand that any appointment(s) cancellation requires 48 hours advanced notice for full refund otherwise there will be a \$50 surcharge applied on each and every examination or therapy missed or cancelled without a notice.

Parent's / Guardian's Signature: _____ Date: _____

Office Witness : _____ Date: _____

Continue on page (3) please

Read through the following list of symptoms that apply to your child's condition now or in the past. Please ignore symptoms that are not related to your child's condition. Please check mark the boxes under the appropriate columns if a symptom is (P) = Past, (F) = Frequent and (C) = Constant then place a numerical value under Value, ie (1 = very low and 10 = very high). Thank you.

GENERAL Sx.				Skeletal Sx.				GASTRO-INTESTINAL Sx.			
NA <input type="checkbox"/>				NA <input type="checkbox"/>				NA <input type="checkbox"/>			
Value	P	F	C	Value	P	F	C	Value	P	F	C
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats (cold or warm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disc hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uric Acid Sx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY Sx.				NA <input type="checkbox"/>				NA <input type="checkbox"/>			
Value	P	F	C	Value	P	F	C	Value	P	F	C
Croup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Growing pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting blood / phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthmatic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle twitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, Chronic/Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A / B / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Middle back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Halitosis (bad breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloated after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sternum joints pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lactose intolerant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness, Reiter's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking Now / Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana Now / Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tennis elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN Sx.				NA <input type="checkbox"/>				NA <input type="checkbox"/>			
Value	P	F	C	Pain (P) or numbness (N) in:				SCALP & HAIR			
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>			
Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C			
Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair lice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair splits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scalp itchy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impetigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scalp painful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melasma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athletes foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair (Dry or Oily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Baldness patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP Sx.			
Brittle Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Bottom of feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA <input type="checkbox"/>			
Skin, ring worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Arch of feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C			
Skin, itch or burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CARDIO-VASCULAR				NA <input type="checkbox"/>			
Sweats profusely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C				Value P F C			
Hives Large or Small	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My child sleep at	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema or Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm Vent, Aorta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	Min.	<input type="checkbox"/>	<input type="checkbox"/>
Feet (Cold or Dry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My child wakes at	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corns on Feet / Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interrupted sleep	X.	<input type="checkbox"/>	<input type="checkbox"/>
Current Treatments, Circle if:				Septal defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you day-nap?	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Proactive	Yes	<input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy all day	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Over the counter	Yes	<input type="checkbox"/>	No <input type="checkbox"/>	Angina / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Meds	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Salicylic Acid Facial	Yes	<input type="checkbox"/>	No <input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Microdermabrasion	Yes	<input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Dyspnea on exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

MOUTH Sx.				HEAD Sx..				ENDOCRINE Sx,			
NA <input type="checkbox"/>				NA <input type="checkbox"/>				NA <input type="checkbox"/>			
Value	P	F	C	Value	P	F	C	Value	P	F	C
Mercury filling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrush on tongue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Juvenile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Puffy face.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snore.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light headed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Protruded eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gums bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cluster Headache....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache after MVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to hot..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache on waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intolerant to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taste changed lately..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache if hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Addison's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drool during sleep ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache per Week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITAL/URINARY Sx. NA <input type="checkbox"/>			
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C			
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNIZATION,ALLERGY Sx. NA <input type="checkbox"/>				Pubic itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes No				Bed wetting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NOSE Sx. NA <input type="checkbox"/>				Immunization (Infant)	<input type="checkbox"/>	<input type="checkbox"/>		Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value P F C				Immunization (Child)	<input type="checkbox"/>	<input type="checkbox"/>		Kidneys stones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose tip itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunization (Teens)	<input type="checkbox"/>	<input type="checkbox"/>		Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed (epistaxis)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy shots Now / Past.	<input type="checkbox"/>	<input type="checkbox"/>		Cannot hold urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flu shots: _____	<input type="checkbox"/>	<input type="checkbox"/>		Kidneys infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others: _____	<input type="checkbox"/>	<input type="checkbox"/>		Burning urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells Am, Pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES Sx. NA <input type="checkbox"/>				Genital Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C				Urine incontinence.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear (Perfume, Cologne)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EARS Sx. NA <input type="checkbox"/>				Fall.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS Sx. NA <input type="checkbox"/>			
Value P F C				Winter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value P F C			
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OCD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear noise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- house dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- dust mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unhappy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear redness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- dairy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Sulfur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perforated eardrum...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADHD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive ear wax...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- weeds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES Sx. NA <input type="checkbox"/>				Allergy- food additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety due to abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value P F C				Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- trees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- grains.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties on eye lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- vegetables..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to worry...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sight (Near or Far) .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loses temper often....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- food.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to cry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bags under eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low self esteem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circle under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- grasses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopeless outlook.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THROAT Sx. NA <input type="checkbox"/>				Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be shy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value P F C				Allergy- animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislike criticism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frightening dreams....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- chemicals ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frightening thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- insects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hard to concentrate....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat irritation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice changed lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy- cosmetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Grand Mal / Petit...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Perfumes: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wets pants constantly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Cologne: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MALIGNANCIES Sx.	NA <input type="checkbox"/>			
	Value	P	F	C
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer	_____			
Malignancy Stage	_____			
Metastasized Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Receiving Chemo	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Receiving Radiation	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Surgeries dates:	NA <input type="checkbox"/>
Hernia operation _____	
Gallbladder removed _____	
Tonsillectomy _____	
Tubes in ears _____	
Appendectomy _____	
Nasal adenoids _____	
Cancer surgery _____	
Knee surgery _____	
Surgery: _____	
Surgery: _____	
Surgery: _____	

List drugs known to you whether :	NA <input type="checkbox"/>		
Medications	Taking	Allergic	Past
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalers Ventolin, Symbicort ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin meds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Tylenol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety meds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warfarin meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gravol /Antacids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chelation Therapy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myer's cocktail IV.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of Tests:	NA <input type="checkbox"/>
Chest X-Ray _____	
Kidney X-Ray _____	
Colon X-Ray _____	
Sinus X-Ray _____	
Gallbladder X-Ray _____	
Electrocardiogram _____	
Sigmoidoscopy _____	
Polio series _____	
Flu shots _____	
Pap Smear _____	
Tetanus shots _____	
Typhoid shots _____	
Mumps shots _____	
Measles shots _____	
Gastro-intestinal series _____	

FOR MATURED MALES	NA <input type="checkbox"/>			
	Value	P	F	C
Testicular hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting issues....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR MATURED FEMALES	NA <input type="checkbox"/>			
	Value	P	F	C
Constant PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congested breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular cycle.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleed between cycles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tampons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral contraceptive...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last cycle _____				

HABITS		
Street Drugs Usage	Current	Past
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

HABITS		
Street Drugs Usage	Current	Past
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Personal Notes

No parental history, child was adopted

Did not have a healthy childhood

HABITS and their frequencies	Value	P	F	C
Water, cups per day: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk Servings Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese Servings Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yogurt Servings Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Cream Serv. Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs # ----- Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine R / W Per day / Wk..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whey Protein Shakes Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butter / Margarine Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutella / Peanut Butter Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate Milk Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar, Sugar Products Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes, Cookies, Candies day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Donuts, Muffins, day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat three meals a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat two meals a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat one meal a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes per day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street drugs now / past.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard drugs now / past.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOUR PARENTS

The following questions pertain to your parents health before and while your mother was pregnant with you. The answer to the following would help determine the strength of your inner constitution.

	Value	Mom	None	Dad
Allergies				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribed drugs				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street drugs/narcotics				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicable diseases				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Notes				
No parental history, I was adopted	<input type="checkbox"/>			
Did not have a healthy childhood	<input type="checkbox"/>			

My Child's Current Diet (Please Complete)

The next table revolves around your child's dietary habits. The intention is to unfold food that contain Aluminium and MSG or whether your child's food stimulates or contains histamine. This may be very beneficial in understanding the real causes behind your child's conditions. Please answer the following questions to the best of your abilities.

My child eats the following during breakfast?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during lunch?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during dinner?

- 1-
- 2-
- 3-
- 4-
- 5-

My child eats the following during during snacks?

Mid-Day:

Afternoon:

Before bed time:

Foods that your child craves?

My child craves the following:

- Chocolate
- Crunchy foods such as chips & crackers
- Caffeine such as coffee, tea, & energy drinks
- Cola, Pop, Soda
- Sugary foods and Desserts
- Hard Candy or Gum
- Protein
- Dairy
- Salty foods
- Fast foods
- Wine with meals
- Beer with meals

My child craves following types of food

- I have a strict dietary plan that I follow
- Most of my meals are home cooked whole foods
- I eat out less often today than I did 5 years ago
- I avoid refined grains, breads & pastas
- I avoid deep fried foods
- I eat sugary foods & dessert less than 3 times wk.
- I avoid diet foods
- I avoid Colas, Pops, Sodas
- I eat gluten free food
- I avoid foods that I have allergies to _____.
- I buy frozen or canned fruits and vegetables

My child consumes fruits and vegetables as follows

My child consumes:

- NO** servings of fruit and vegetables at all
- Fruits &/or vegetables during breakfast
- Fruits &/or vegetables during lunch
- Fruits &/or vegetables during dinner
- Fruits &/or vegetables for snacks
- I make time to eat fruits &/or vegetables daily
- I prepare **fresh** fruits & vegetables
- I prepare **canned** or **frozen** fruits & vegetables

My child eats the following

My child consumes:

- A wide variety of **organic** fruits
- A wide variety of **regular** fruits
- A wide variety of **organic** vegetables
- A wide variety of **regular** vegetables
- A wide variety of vegetables
- A wide range of green leafy vegetables
- A wide color range of fruits & vegetables
- Broccoli, cauliflower, kale & Brussels sprouts
- I add Lemon / Lime juice to my salad

My child digestion is best describes as follows

- My child is often bloated
- My child has low energy after eating
- My child is often constipated
- My child's brain is foggy after eating
- My child has a general digestive upset after eating
- My child has excess mucus after eating
- My child has gas or flatulence
- My child has acid reflux &/or heartburn
- Having a bowel movement is often difficult
- My child runs to the bathroom after food
- My child's stool varies in size & consistency

My child consumes the followings

My child must add the following to food

- Vinegar
- Balsamic Vinegar
- Apple Cider
- Cheese
- Butter
- Mayonnaise
- I am hungry & often don't know why
- White sugar
- Salt
- MSG

I do not understand why my child has the following symptoms

My child always feel like

- Eating often eat when I feel guilt or depressed
- Eating & not knowing why
- Eat to reward myself
- I often eat when I am low energy especially in the
- I am hungry & often don't know why

The following section is required to list your child's medical history, sicknesses, rough times and hospitalizations, I am interested in every medication given to your child especially antibiotics, cortisone and oral contraceptive pill. You should list the starting year of diseases and the year of their cure such as tonsillitis, ears, lungs, throat, skin smoking, street drugs etc. Also list the year of admission to hospital for whatever reason.

SEE AN EXAMPLE IN THE NEXT PAGE.

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. *You may choose to fill this sheet with your doctor before your examination.*

Some important notes to consider are

1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind,

Duration	Year	Age	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _ _ months & started solid food at _ _ months.		
		Yr. of Birth			
		3 Months			
		6 Months			
		9 Months			
		1 Yr.			
		3 Months			
		6 Months			
		9 Months			
		2 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		3 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		4 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		5 Yrs.			
		6 Yrs.			
		7 Yrs.			
		8 Yrs.			
		9 Yrs.			
		10 Yrs.			
		11 Yrs.			
		12 Yrs.			
		13 Yrs.			
		14 Yrs.			
		15 Yrs.			
		16 Yrs.			

Please add another sheet

Fees of Examinations and services

Fees for first examination and intravenous therapy are pre-paid at time of booking the appointment by cash, Visa, Master Card, American Express and Interac. **We do not bill insurance companies.**

Choice	Code	Explanation	Our fee schedule
✓	EX1-Child	Discuss symptoms + Medical History + First Examination + Food caution = 1½ Hrs. (Remedies and / or blood work are not included)	\$175.00 Non-Taxable
	EX-5	Subsequent follow up 30 Mins. (Remedies are not included)	\$ 065.00 Non-Taxable
	Cancellation Fees	All cancellations are not chargeable if done 48 Hrs. prior to the scheduled appointments. There is a fee for un-cancelled appointments.	\$ 050.00 Non-Taxable

Hints to help you fill in this medical history application:

The following are some hints on how to fill the application form as accurate as possible. Every question has two forms of answers. The first group of answers are placed under **Value** which explains the intensity of the symptom when it come using numbers from (1 to 10). Intensity of a symptom has nothing to do with the frequency of the symptom whether daily or once a week or one a month.

Number (1 to 3) indicates the symptom's intensity is very small when it comes. On the other hand, a number (4 or 7) indicates that the symptom's intensity is disturbing and bothersome when it comes. The number (8 to 10) symptom's intensity is very painful whether the symptom appears every day or once a month. You should assign or estimate number to every question as you see it. This is not a right or wrong questions.

The second group of answers determines whether a symptom should be marked as **one** of the following answers

- C... symptoms are present daily or
- F... symptoms come and go frequently every few days, every week or every month or
- P... symptoms appear every several months or every season.

For example:

GASTRO-INTESTINAL

Value	P	F	C		
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gas	Gas here is a constant symptom that appears daily and little bothersome given number 3.
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Jaundice	
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	
⑦	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart burn	Heart burn here is a constant daily symptom that appears which is very disturbing given the number 7.
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion	
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation	
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Poor appetite	Poor appetite here is a moderate symptom that appears frequently and bothersome, given the number 3
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Liver trouble	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Colon trouble	
②	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain over stomach	Pain over stomach here is a daily symptom, with a little discomfort, given the number 2.
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc.

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. **You may choose to fill this sheet with your doctor before your examination.**

Some important notes to consider are:

- 1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.

Duration	Year	Age	Description of incidents
	(2006)	Birth Day	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _ ? months & started solid food at _ ? months.
	2007	1	Was not breast fed, used formula
		2	
		3	1 st set of tubes in the ears
		4	
		5	
		6	2 nd set of tubes in ears plus antibiotics
	2013	7	
		8	Asthmatic symptoms, inhalers were prescribed and used daily
	2015	9	
		10	
		11	3 rd set of tubes in the ears
	2018	12	
		13	
		14	
		15	
		16	
		19	Asthma symptoms disappeared
		20	Motor vehicle accident, hospitalized for broken leg

Please be as specific as possible since the medical history may hold the key to your complete recovery.