



**PATIENT REGISTRATION FORM – NATUROPATHY (CHILD)**

Welcome to Nobleton Physiotherapy. Please take a moment to complete the following registrations forms. Thank you.

Date: \_\_\_\_\_ Preferred Pronoun: He / She / Other  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth (d/m/y): \_\_\_\_\_ Gender:  M  F  Other

Contact information for parent or legal guardian:

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Ste/Box#: \_\_\_\_\_  
City, Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_

With whom does the child live? \_\_\_\_\_ Permission to leave messages?  Yes  No

How did you hear about us?  Family MD Referral  Word of Mouth  Website  Google  
 Friend/Family member  Other \_\_\_\_\_

Canadian legislation (CASL) now requires we gain your consent to communicate with you through email. Below is a list of items we may communicate to you through email. Please check the appropriate box(es).

**Appt. Reminders:** For your convenience, NP can send email reminders for your upcoming appointments.  
Would you like us to use your email for this service?  Yes  No Thanks

**Health Professional Communication:** During your treatment period your health provider may send you information regarding your injury or exercises to support your recovery.  
Would you like us to use your email for this service?  Yes  No Thanks

**Clinic Newsletter:** On a semi-monthly basis we will be sending out a newsletter to update you on news/events within the clinic and educational tips for health and injury prevention.  
Would you like us to use your email for this service?  Yes  No Thanks

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_



Is this your first time seeing a Naturopathic Doctor?  Yes  No

**Other Health Care Practitioners**

**Family Doctor:**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Last visit: \_\_\_\_\_

**Specialist:**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Last visit: \_\_\_\_\_

**Health Goals / Reason for visit (in order of importance)**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Current Diagnoses, Illness, or Recent Hospitalizations**

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**Allergies:** \_\_\_\_\_

**Current Medications and Natural Health Products**

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

How would you describe your child's general state of health?  Good  Fair  Poor

How many times has your child been treated with antibiotics? \_\_\_\_\_

Which screening tests has your child had (blood, hearing, vision, etc.) \_\_\_\_\_

**Immunizations**

- DPT (diphtheria, pertussis, tetanus)
- MMR (measles, mumps, rubella)
- Polio
- Chickenpox
- Tetanus booster: when? \_\_\_\_\_
- Rotavirus
- HPV/ Gardasil

- HiB
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal conjugate
- Meningococcal conjugate
- Other: \_\_\_\_\_

**Food Allergies, Intolerances or Dietary Restrictions:**

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**Personal and Family Medical History**

Has your child had any of the following illnesses?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Rubella (German Measles) | <input type="checkbox"/> Roseola        | <input type="checkbox"/> Impetigo       |
| <input type="checkbox"/> Measles                  | <input type="checkbox"/> Scarlet Fever  | <input type="checkbox"/> Mononucleosis  |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Strep Throat   |   |

Please check the “yes” box next to each condition that applies to you and/or one of your family members. **(Self)** relates to you, **(F)** Father, **(M)** Mother, **(S)** Sibling, **(G)** Grandparent, and **(C)** Your Child. Please circle **Current** if the condition is ongoing, and **Past** if the condition has resolved.

	Yes (✓)	Relation (circle)	Resolved		Yes (✓)	Relation (circle)	Resolved
Addiction		Self F M S G C	Current / Past	High Blood Pressure		Self F M S G C	Current / Past
Allergies		Self F M S G C	Current / Past	Heart Disease		Self F M S G C	Current / Past
Anemia		Self F M S G C	Current / Past	Hepatitis		Self F M S G C	Current / Past
Arthritis		Self F M S G C	Current / Past	Headaches		Self F M S G C	Current / Past
Asthma		Self F M S G C	Current / Past	Kidney Disease		Self F M S G C	Current / Past
Cancer		Self F M S G C	Current / Past	Stroke		Self F M S G C	Current / Past
Diabetes		Self F M S G C	Current / Past	Tuberculosis		Self F M S G C	Current / Past
Eczema		Self F M S G C	Current / Past	Osteoporosis		Self F M S G C	Current / Past
Epilepsy		Self F M S G C	Current / Past	Other:		Self F M S G C	Current / Past
Mental illness		Self F M S G C	Current / Past				

I don't know my child's medical history.

Does either parent have a chronic illness? \_\_\_\_\_

**Prenatal Health**

How was the pregnancy, any complications (gestational diabetes, hypertension, jaundice)?

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Birth:  Vaginal  C-Section  Induced

Term:  Full  Premature  Late By how much? \_\_\_\_\_ wks

How was your child fed?  Breast milk  Formula  Which brand? \_\_\_\_\_

When was food introduced? \_\_\_\_\_

**Environment**

How would you describe your child's temperament? \_\_\_\_\_

How would you describe your child's behavior and performance at school? \_\_\_\_\_

What is your child's sleep like? \_\_\_\_\_

Hobbies: \_\_\_\_\_

Exercise (type, duration): \_\_\_\_\_

How many hours per day does your child spend:

\_\_\_\_\_ Watching television

\_\_\_\_\_ Playing video games

\_\_\_\_\_ On a computer or tablet

\_\_\_\_\_ On a cellphone

How often does your child read books (not for school), or get read to?

Daily

Several times a week

Weekly

Less than weekly

Tobacco exposure: \_\_\_\_\_ Exposure to animals: \_\_\_\_\_

How is your home heated? \_\_\_\_\_ Regularly exposed to chemicals, paints, and metals? \_\_\_\_\_

Sensitive to smells, perfumes, and other vapours? \_\_\_\_\_

How stressful is your life? \_\_\_\_\_

How would you describe the emotional climate of your home? \_\_\_\_\_

Is there anything else important you feel has not been covered? \_\_\_\_\_

Print Name of Child: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name of Parent/ Legal Guardian: \_\_\_\_\_

Signature of Parent/ Legal Guardian: \_\_\_\_\_