PATIENT NAME:			
DATE OF BIRTH (DAY/MO/YR): / /			
ADDRESS (HOME):		FIRST CANADIAN HEA	ALTH NO. (IF APPLICAE
		— IN CASE OF EMERGE	NCY, WE SHOULD NO
PHONE (HOME):		NAME:	
PARENT OR LEGAL GUARDIAN NAME:		RELATIONSHIP:	
PHONE (WORK and/or CELL):			
EMAIL:		PHONE OR ADDRESS:	
-	-	Last de rienced any of the following?	
Asthma	Cancer	Liver Disease	General Anes
Sleep Apnea/Snoring Tuberculosis	Bleeding Disorder Thyroid Condition	Jaundice Stroke	Dental Traum MRSA
Pneumonia/Bronchitis	Stomach Ulcers	HIV/AIDS	Hearing Disor
Anemia	Gastric Reflux	Brain injury	Eye Disorder
Seizures	Diabetes	Abuse/Neglect	ADHD
Heart Condition	Kidney Disease	Hospitalization	
		hiatric or developmental cond	
Are your child's immuniza	tions up to date? □ Yes □	No	
		□Withdraws □Warms up □	Flexible/Extroverted
How does your child/charg	ge cope in new situations?	= = =	
		nger sucking □ lip/fingernai	l biting □ pacifier □
Does your child/charge ha	ave any habits? □ thumb/fi		
Does your child/charge ha	ave any habits? □ thumb/fi	nger sucking   □ lip/fingernai ng   □drinking from sippy-cup	
Does your child/charge ha	ave any habits? □ thumb/fi east feeding □bottle feedir	nger sucking □ lip/fingernai ng □drinking from sippy-cup k/day □more than 3x/day	
Does your child/charge hat Is your child/charge: □br Frequency of snacks per of <b>To the best of my knowl</b>	ave any habits? □ thumb/fi east feeding □bottle feedir day? □2x/day □3 timex ledge, the above information	nger sucking □ lip/fingernai ng □drinking from sippy-cup k/day □more than 3x/day	5?