

Dr. Rebecca Cannon ND
69 Arthur St S Suite 204, Elmira ON N3B 2M8
Minor Intake Form

Name: _____ Date: _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Phone (H): _____ Circle : Male Female
Date and Place of Birth: _____
Emergency Contact (relation): _____ Phone: _____
Name of Medical Doctor: _____ Phone: _____
How did you hear about the office? _____

This is a confidential record of a minor's medical history and will be kept only in this office unless authorized by the parent or legal guardian of the above patient.

What are the health concerns of your child?

Please list any medications and/or supplements with dosage:

Please list any surgeries, hospitalizations or major illnesses in history:

Is your child up to date on his/her vaccinations? _____

Are there any vaccines you opted out of? _____

Are there any extra vaccines your child has been given? _____

Please list any adverse effects after vaccines:

Does your child have any allergies or intolerances (food, environmental) ? _____

Please fill in the following chart as it pertains to the patient:

	Age	State of Health
Mother	_____	_____
Father	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____

Child's Birth Weight: _____ Present Weight: _____ Present Height: _____

What does your child like to eat? _____

What does your child not like to eat? _____

Are there any foods that make your child ill? _____

Does your child do anything unusual in his/her sleep? _____
Does your child wake rested? _____

Signature of Parent/Guardian:

I attest that the information provided is true and accurate to the best of my knowledge. I hereby provide consent to the touch and treatment of the above patient for the purpose of examination and care.

Signature: _____ Date: _____

I authorize Rebecca Cannon ND to contact me via electronic mail (email). I am aware that the office of Rebecca Cannon ND does not have encrypted email software and cannot guarantee that information transmitted via email will not be intercepted by other parties. By signing this form, I agree not to hold Rebecca Cannon ND responsible for any breach of confidentiality that may occur by someone else accessing the information contained in any emails sent to or from Rebecca Cannon ND regarding my personal health information. I understand that reasonable means will be used to protect the security and confidentiality of the email. My email will not be forwarded outside the office without my consent.

Signature: _____ Date: _____