



West Vancouver Wellness Centre
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www.healthydoc.com

Confidential Pediatric/Adolescent Case History

Name: _____ Date: _____

Address: _____

Postal Code: _____ Date of birth ___/___/___ Age ___
 (m) (d) (yr)

How did you hear about us? _____

Parent(s) Contact: Name _____ Tel (h) _____

Email _____ Tel (w/c) _____

Please list your main health concerns in order of importance:

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

Medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other _____	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other _____	_____	_____

Childhood illnesses:

<input type="checkbox"/> chicken pox	<input type="checkbox"/> scarlet fever	<input type="checkbox"/> mononucleosis
<input type="checkbox"/> red measles	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> ear infection(s)
<input type="checkbox"/> mumps	<input type="checkbox"/> strep throat	<input type="checkbox"/> tonsillitis
<input type="checkbox"/> rubella	<input type="checkbox"/> pneumonia	<input type="checkbox"/> other _____

Immunizations: List types, when given, and any reactions: _____

Prenatal/birth/neonatal history:

Birth weight _____ premature late full term

Mother's health during pregnancy:

<input type="checkbox"/> age	<input type="checkbox"/> bleeding	<input type="checkbox"/> extreme nausea
<input type="checkbox"/> illness	<input type="checkbox"/> toxemia	<input type="checkbox"/> trauma / injury
<input type="checkbox"/> stress	<input type="checkbox"/> x-rays	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> diabetes	<input type="checkbox"/> medications	<input type="checkbox"/> cigarettes
<input type="checkbox"/> alcohol	<input type="checkbox"/> drugs	<input type="checkbox"/> other _____

Infant feeding:

___ breast fed: if yes, how long? _____

___ formula fed: how long and types of formula? _____

Age solids began: _____ What foods? _____

Food allergy/intolerance(s) _____

Favourite foods: _____

Sample daily diet: choose a typical day, include liquids

Hospitalizations/surgeries/accidents/serious injuries and illnesses: (describe each incident and give dates)

Family History

Identify all family members who have or have had any of the following:

___	_____	alcoholism	___	_____	allergies
___	_____	anemia	___	_____	arthritis
___	_____	asthma	___	_____	diabetes
___	_____	eczema	___	_____	epilepsy
___	_____	heart disease	___	_____	hearing loss
___	_____	hypoglycemia	___	_____	mental illness
___	_____	obesity	___	_____	stroke
___	_____	thyroid disorder	___	_____	other(s) _____

Patient's Health History

Now	Past	Never		Now	Past	Never	
___	___	___	allergies	___	___	___	fatigue
___	___	___	anemia	___	___	___	frequent infections
___	___	___	asthma	___	___	___	headaches
___	___	___	bedwetting	___	___	___	heart murmur
___	___	___	birth defects	___	___	___	high fever
___	___	___	colic	___	___	___	hyperactivity
___	___	___	cough/wheeze	___	___	___	insomnia
___	___	___	croup	___	___	___	jaundice
___	___	___	depression	___	___	___	learning problem
___	___	___	diarrhea	___	___	___	moodiness
___	___	___	dry skin	___	___	___	stuffy nose
___	___	___	earache(s)	___	___	___	thrush
___	___	___	eczema/rash	___	___	___	vomiting spells

Others: please list: _____

CONSENT FORM

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, cranio-sacral therapy, clinical nutritional, lifestyle counselling, and intravenous nutritional therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure result.

Signature x _____ Date x _____

Doctor's Signature x _____

PARENTAL CONSENT (if applicable)

If you are under the age of 19, parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x _____ Date x _____

PREMIUM ASSISTANCE ELIGIBILITY (if applicable)

Individuals who may be eligible for premium assistance via Medical Services Plan need to include their Personal Health Number ensure accurate billing.

Care Card # _____