Delbrook Naturopathic Medical Centre Inc.

Dr. D. Bayley BSc.K, ND

Confidential Medical History – **Pediatric**

CARE CARD #:____________________________ BIRTHDATE:_______________________

FULL NAME: ____ DATE: _________________
ADDRESS: ____POSTAL CODE: ____________
HOME PHONE: _______________ WORK: _______________ CELL: _________________ MOTHER/FATHER
EMAIL: ____

APPOINTMENT REMINDERS: How would you like us to contact you? Email, text, or home?_____________

AGE: ____ SEX: ____ MOTHER'S NAME: ______________________ FATHER'S: ______________________
DID SOMEONE REFER YOU? ____________________________

HAVE YOU SEEN OTHER PHYSICIANS OR THERAPISTS IN THE PAST YEAR? IF SO, PLEASE LIST THE NAME AND TYPE: ____
____
PRESENT COMPLAINT(S) OR ILLNESS(ES) IS/ARE: ____

DURATION: ____

MEDICATIONS	NOW	PAST		NOW	PAST
Asprin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histimine	____	____
Decongestant	____	____	Other	____	____
Ibuprofin	____	____	Allergies to Medications	____	____

MEDICAL HISTORY

Childhood Illnesses

____	Chicken Pox	____	Scarlet Fever	____	Tonsilitis (approx. #)
____	Measles	____	Pneumonia	____	Ear Infections (approx. #)
____	Mumps	____	Frequent colds	____	Other (please list)
____	Rubella	____	Rheumatic Fever	_____________________________	

INJURIES/SURGERIES/HOSPITALIZATIONS (please list) ____
____

IMMUNIZATIONS

___Measles ___Polio ___MMR ___Small Pox ___Diptheria ___Mumps ___DPT
___Tetanus ___Influenza ___other

FAMILY HISTORY:

___ Heart Diseaes ___Diabetes ___ Birth Defects ___ Hypertension ___ Arthritis
___ Tuberculosis ___Cancer ___ Allergies ___ Mental Illness

HAS THE CHILD HAD ANY OF THE FOLLOWING PROBLEMS?

___ Jaundice ___Diarrhea ___Birth Defects ___ Rashes ___ Colic ___ Fever
___ Allergies ___ Blue Baby ___ Cerebral Palsy ___ Seizures ___ Birth injuries ___ Other

Childs sleep patterns first year:____
Food intolerences (if any): ____

FEEDING:

Breast Fed? ___ How long? ______ Formula? ___ Milk? ___ Soy? ___
Solid foods introduced ___________________________
Age began: Sitting alone ___ Crawling ___ Walking ___ First words ___

Symptoms (mark P for PAST, N or NOW)

___ Hives ___Burning of urine ___Bloody urine ___ Eczema
___ Frequent urination ___ Cries easily ___ Bleeding ___ Heart Murmur
___ Nervous ___ Nose bleeds ___ Acne ___ Vomiting spells
___ Sleep problems ___ Anemia ___ Night sweats ___ High fevers
___ Stomach aches ___ Sensitive to light ___ Jaundice ___ Chronic fevers
___ Easy bruising ___ Body/breathe odor ___ Hearing loss ___ Decrease in appetite
___ Diarrhea ___ Flat feet ___ Sore throats ___ Motion or car sickness
___ Constipation ___ Nightmares ___ Gas ___ Canker sores
___ Unusual fears ___ Wheezing ___ Frequent cold ___ Frequent Headaches
___ Joint pains ___ Excessive fatigue ___ Bleeding tendency ___ Cough
___ Dizzy spells ___ Hair loss

Do you have any concerns about our child's behaviour? If so, please explain ______________________
____

MOTHERS HEALTH DURING PREGNANCY:

___ Bleeding ___ Nausea ___ Illnesses ___ Diabetes ___ Hypertension
___ Thyroid problems ___ Physical or emotional trauma
___ Cigarettes, alcohol, drug consumption

Mothers age at birth of patient: ____
TERM: Full ___ Premature ___ Late ___ Weight at birth ___
Length of labour: ___
PREVIOUS HISTORY: # of previous pregnancies ___ Miscarriages ___
Complications ________________________ Medications ______________________________________

CANCELLATION POLICY

Life happens, so you may need to cancel or re-schedule your appointment. Please call us at least 24 hours in advance. A cancellation with less than 24 hours notice (or no-show) will result in charges to your account.
Less than 24 hours notice cancellation or re-schedule is $42.00.
Missed appointments are subject to a fee of $85.00

I agree to the above policy _________________________ (Please sign)