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 intolerances (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 behavior? 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 ____

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I Agree: (parent or guardian)____

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

I Agree: (parent or guardian) ____