MARINE DRIVE
NATUROPATHIC CLINIC

101-1277 Marine Drive Naturopathic Clinic, North Vancouver BC V7P 1T3 (604) 929-5772

"Get your life back, not your symptoms" ™

Successful health care and preventative medicine are possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. If you have any questions, mark them with a question mark. Thank you!

Confidential Pediatric/Adolescent Case History

Date: _____Name: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Work #: _____Cell #: _____

Date of birth (D/M/Y) _____ Sex (M/F)_____

Person to Contact in Emergency (Parent):

Name _____ Relationship _____ Telephone: _____

How did you hear about us? _____

Email Address: (for email appointment reminders) _____

Would you like to receive clinic newsletters/information via email? Yes No

Please list your main health concerns in order of importance:

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

Medications:

	NOW	PAST
Aspirin	☐	☐
Tylenol	☐	☐
Antibiotics	☐	☐
Other_____	☐	☐

Supplements:

	NOW	PAST
Vitamins	☐	☐
Minerals	☐	☐
Fluoride	☐	☐
Other_____	☐	☐

Childhood illnesses:

☐ Chicken Pox	☐ Scarlet fever	☐ Mononucleosis	☐ Mumps
☐ Red measles	☐ Rheumatic fever	☐ Ear infection(s)	☐ Strep Throat
☐ Rubella	☐ Pneumonia	☐ Tonsillitis	☐ Other_____

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

_____

_____

_____

Prenatal/birth/neonatal history:

Birth Weight_____ ☐ Premature ☐ Late ☐ Full Term

Mother's health during pregnancy:

- ☐ Age_____
- ☐ Toxemia
- ☐ High blood pressure
- ☐ Alcohol
- ☐ Bleeding
- ☐ Trauma/injury
- ☐ Diabetes
- ☐ Drugs
- ☐ Extreme Nausea
- ☐ Stress
- ☐ Medications
- ☐ Other_____
- ☐ Illness
- ☐ X-rays
- ☐ Cigarettes
- ☐

Place of birth_____

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:

	Family Member		Family Member
☐ Alcoholism		☐ Allergies	
☐ Anemia		☐ Arthritis	
☐ Asthma		☐ Diabetes	
☐ Eczema		☐ Epilepsy	
☐ Hearing loss		☐ Hypoglycemia	
☐ Heart Disease		☐ Mental illness	
☐ Obesity		☐ Stroke	
☐ Thyroid Disorder		☐ Other_____	

Patient's Health History:

	NOW	PAST		NOW	PAST
Allergies	☐	☐	Fatigue	☐	☐
Anemia	☐	☐	Frequent Infections	☐	☐
Asthma	☐	☐	Headaches	☐	☐
Bedwetting	☐	☐	Heart murmur	☐	☐
Birth Defects	☐	☐	High fever	☐	☐
Colic	☐	☐	Hyperactivity	☐	☐
Cough/Wheeze	☐	☐	Insomnia	☐	☐
Croup	☐	☐	Jaundice	☐	☐

Depression	☐	☐	Learning problems	☐	☐
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.

I understand the visit costs for Naturopathic treatment are as follows:

Initial Pediatric Consultation (1 hour) $140.00
Subsequent Pediatric visits (30 minutes) $75.00
Subsequent visits are 30 minutes

I understand that if I miss an appointment or cancel on short notice (less than 24 hours) I may be charged a fee for the missed appointment.

Signature x_____ Date x_____
Doctor's Signature x_____ Date 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 #_____

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help us decipher what is going on so we can come up with the steps that will lead you to vibrant health!