



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	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Supplements:

NOW PAST

Vitamins	<input type="checkbox"/>	<input type="checkbox"/>
Minerals	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Childhood illnesses:

- | | | | |
|--------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Red measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ear infection(s) | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis | <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 _____ | <input type="checkbox"/> |

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 |
|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Other _____ |

Patient's Health History:

	NOW	PAST		NOW	PAST
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Infections	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	High fever	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Cough/Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Croup	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

Depression	<input type="checkbox"/>	<input type="checkbox"/>	Learning problems	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	Stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>
Earache (s)	<input type="checkbox"/>	<input type="checkbox"/>	Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/rash	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting spells	<input type="checkbox"/>	<input type="checkbox"/>

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) \$175.00
 Subsequent Pediatric visits (30 minutes) \$80.00
 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!