

Health History Questionnaire (Paediatric)

By completely filling out the form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you!

Name _____ Age _____ M F Today's Date _____
 Care card number _____ Birth date (M/D/Y) _____
 Home Address _____ City _____
 Postal Code _____ Telephone number _____

Mothers Name _____ Father's Name _____
 Home/Cell number _____ Home/ Cell number _____
 Work number _____ Work number _____
 Email address _____ Email Address _____
 Names of Siblings _____

Names of Other Health Care Providers
 Medical Doctor _____ Naturopathic Physician _____
 Chiropractor _____ Others _____

Who referred you to our clinic? _____

Your Main Health Concerns

Why are you coming to our clinic today?

When did your problem(s) begin (be specific)?

Family Medical History

Please indicate family member, and if on father's (F) or mother's (M) side of family

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other (Please Specify) _____ | | |

Birth Information

Method of Birth: _____ Any Interventions? _____

Apgar Score: _____ Date of birth relative to due date : _____

Diet

Was the infant nursed? Y/N If yes, for how long? _____

List any formulas _____

At what age was formula introduced? _____

Please list first foods introduced and corresponding age _____

Please list any bad reactions to foods _____

Please describe your average daily diet

Morning

Afternoon

Evening

Milestones

Please list age of the child when the milestone was reached. (If you remember!)

Sat up _____ Crawled _____ First tooth _____ Walked _____

Rollled over _____ Pulled to stand _____ First words _____ Toilet trained _____

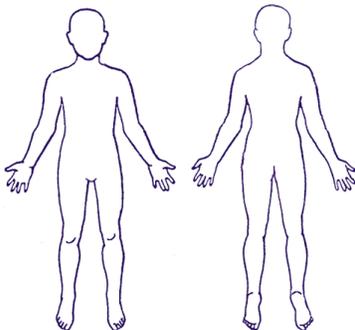
Current Medicines

List all prescriptions, over-the-counter drugs, vitamins, herbs, and any non-medical drugs. If you are a nursing Mother, please include any of the above that you may be taking

Please list any Vaccinations Received

Please briefly describe your pregnancy with this child

Indicate painful or distressed areas:



Please enter the patient's medical history. Leave blank if it does not apply.

	YES	NO	Details	DATE
GENERAL				
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>		
Surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Accident(s)	<input type="checkbox"/>	<input type="checkbox"/>		
Emotional trauma	<input type="checkbox"/>	<input type="checkbox"/>		
SKIN				
Cradle Cap	<input type="checkbox"/>	<input type="checkbox"/>		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>		
Diaper Rash	<input type="checkbox"/>	<input type="checkbox"/>		
Hair Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Nail Biting	<input type="checkbox"/>	<input type="checkbox"/>		
MUSCULOSKELETAL				
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		
Bone Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>		
DENTAL				
Teething Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Dental Caries	<input type="checkbox"/>	<input type="checkbox"/>		
DIGESTION				
Gas	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Hunger excess/deficiency	<input type="checkbox"/>	<input type="checkbox"/>		
Thirst excess/deficiency	<input type="checkbox"/>	<input type="checkbox"/>		
Cravings	<input type="checkbox"/>	<input type="checkbox"/>		
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		
Stomach Aches	<input type="checkbox"/>	<input type="checkbox"/>		
GENITO-URINARY				
Urinary-tract infections	<input type="checkbox"/>	<input type="checkbox"/>		
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>		
Urinary Urgency	<input type="checkbox"/>	<input type="checkbox"/>		
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>		
METABOLISM				
Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>		
Excessive/ night sweating	<input type="checkbox"/>	<input type="checkbox"/>		
EMOTIONAL				
Irritability	<input type="checkbox"/>	<input type="checkbox"/>		
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>		
Fears	<input type="checkbox"/>	<input type="checkbox"/>		
Aversions	<input type="checkbox"/>	<input type="checkbox"/>		
EYES, EARS, NOSE, THROAT				
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>		

Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		
Myringotomy tubes	<input type="checkbox"/>	<input type="checkbox"/>		
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>		

	YES	NO	Details	DATE
EYES, EARS, NOSE, THROAT				
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>		
“Strep” Throat	<input type="checkbox"/>	<input type="checkbox"/>		
Coughs	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>		
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>		
CHILDHOOD ILLNESSES				
Rubella	<input type="checkbox"/>	<input type="checkbox"/>		
Measles	<input type="checkbox"/>	<input type="checkbox"/>		
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>		
Mumps	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Scarlett Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER				
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

COMMENTS

Please describe any other problems you would like to discuss

*If you like what we do, tell everyone. If you have concerns, tell us.
To health and happiness! Congratulations on your new journey.*

The Village Clinic

Consent Form for Naturopathic Medicine

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent capacity to heal itself. Your Naturopathic Physician will take a thorough case history, may perform a pertinent physical exam and may suggest lab work or request copies of lab work previously completed by your family physician or specialist.

Please inform your Naturopathic Physician of any disease process you are suffering from and any medications, over the counter drugs and supplements you are taking. Please advise your Naturopathic Physician if you are nursing, pregnant or become pregnant throughout the course of your treatment.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, benefits, risks, side effects and, in each case, the consequences of not having the diagnosis and/or treatment acted upon.

As with any form of medical intervention, there can be risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, bruising or injury from injections
- fainting or puncturing of an organ with acupuncture needles

All visits are confidential. We are committed to preserving and safeguarding your right to privacy. A record will be kept of the health services provided to you. The record will be kept confidential and will not be released to others unless so directed by you or if the law requires it.

If required, the Naturopathic Physician may discuss your case with other healthcare providers. I give permission to the physicians and practitioners at The Village Clinic to collaborate on my case. _____
Initial

I understand that results are not guaranteed. I do not expect naturopathic physicians to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to naturopathic and collaborative care from The Village Clinic. I intend this consent form to cover the entire course of my treatment at The Village Clinic. I understand that I am free to withdraw my consent at any time.

Patient name: (please print) _____

Signature of patient or guardian: _____

Signature of Dr. Heli McPhie, ND: _____