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!

Date _____

Name_____ Age _____ Male □ Female □ They □
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

□ Cancer	□ High Blood Pressure	□ Asthma
□ Diabetes	□ Heart Disease	□ Allergies
□ Seizures	□ Stroke	□ Osteoporosis

□ 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 _____
Rolled 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

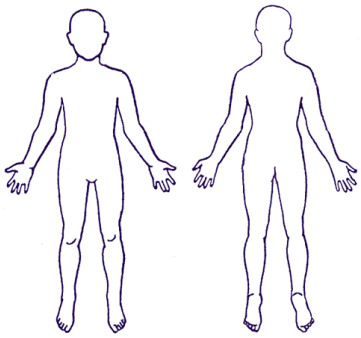
Please list any Vaccinations Received

_____
_____
_____

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	☐	☐		
Surgery	☐	☐		
Accident(s)	☐	☐		
Emotional trauma	☐	☐		
SKIN				
Cradle Cap	☐	☐		
Eczema	☐	☐		
Diaper Rash	☐	☐		
Hair Problems	☐	☐		
Nail Biting	☐	☐		
MUSCULOSKELETAL				
Muscle weakness	☐	☐		
Fatigue	☐	☐		
Bone Problems	☐	☐		
Joint Problems	☐	☐		
DENTAL				
Teething Problems	☐	☐		
Dental Caries	☐	☐		
DIGESTION				
Gas	☐	☐		
Constipation	☐	☐		
Diarrhea	☐	☐		
Hunger excess/deficiency	☐	☐		
Thirst excess/deficiency	☐	☐		
Cravings	☐	☐		
Vomiting	☐	☐		
Stomach Aches	☐	☐		
GENITO-URINARY				
Urinary-tract infections	☐	☐		
Urinary frequency	☐	☐		
Urinary Urgency	☐	☐		
Bed Wetting	☐	☐		
METABOLISM				
Heat/cold intolerance	☐	☐		
Excessive/ night sweating	☐	☐		
EMOTIONAL				
Irritability	☐	☐		
Nightmares	☐	☐		
Fears	☐	☐		
Aversions	☐	☐		
EYES, EARS, NOSE, THROAT				
Vision Problems	☐	☐		

Hearing Problems	☐	☐		
Ear Infections	☐	☐		
Myringotomy tubes	☐	☐		
Sore Throats	☐	☐		

	YES	NO	Details	DATE
EYES, EARS, NOSE, THROAT				
Tonsillitis	☐	☐		
"Strep" Throat	☐	☐		
Coughs	☐	☐		
Frequent Colds	☐	☐		
Nose Bleeds	☐	☐		
CHILDHOOD ILLNESSES				
Rubella	☐	☐		
Measles	☐	☐		
Chickenpox	☐	☐		
Mumps	☐	☐		
Rheumatic Fever	☐	☐		
Scarlett Fever	☐	☐		
Pneumonia	☐	☐		
Allergies	☐	☐		
OTHER				
	☐	☐		
	☐	☐		

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) _____ Date: _____

Signature of patient or guardian: _____

Signature of Dr. Heli McPhie, ND: _____