ACTIVE HEALTH INSTITUTE

Dr **Andréa Proulx** ***ND, RAc***

PEDIATRIC form

Welcome to your initial naturopathic consultation. Please take the time to fill out this form in order to give me background information needed to fully address all of your concerns. This will take approximately 15 minutes.

Name: _____

Date of Birth: _____ (d/m/y)

Gender: ___FEMALE_____MALE _____

Address:_____
_____
_____
_____

Tel #: _(____)_____ Home
_(____)_____ Cell

Parent Email: _____

Parent Work tel #: _(____)_____

Emergency Contact:_____

Emergency Contact Tel #:_(___)_____

Contact relationship: _____

EMAIL	TEL	Preferred method of communication
YES	NO	May the clinic leave messages relating to your visits?
YES	NO	Can I send you my quarterly newsletter via email? (Your contact information will Not be shared.)
YES	NO	Are you currently seeing another member of the Nepean Sports Med Centre team? If so, whom: _____

How did you hear about Dr Andréa Proulx, ND?: _____

Members of your Health Care Team:

Medical Doctor
Name: _Dr._____
Tel #: _(___)_____
Address: _____
_____

Dentist: Dr._____
Tel #: _(___)_____
Address: _____
_____

Specialist: Dr _____
Profession: _____
Tel #: _(___)_____
Address: _____
_____

Specialist: Dr _____
Profession: _____
Tel #: _(___)_____
Address: _____
_____

The Patient's Health Concerns

What are your health concerns, or reasons for coming to the clinic, in order of importance:

1. _____

2. _____

3. _____

Patient's Personal Medical History

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations:

Injury, condition, illness, hospitalization	*Approx. date*	*Condition still present?*	
		Yes	No
		Yes	No
		Yes	No
		Yes	No

Please list all allergies, sensitivities or reactants:

Allergies or Sensitivities			*Severity of reaction*
Yes	No	Pollen: (types)	
Yes	No	Dust	
Yes	No	Animal dander: (types)	
Yes	No	Latex	
Yes	No	Food: (types)	
Yes	No	Other:	

Please list *current* prescriptions & supplements

Medication / Supplement	*Dosage*	*Prescribing Physician*	*Condition Treated*	*Start date*

PRENATAL HISTORY:

Duration of Pregnancy:_____
Any fetal testing (eg. Ultrasounds, amniocentesis)?_____
Any complications during pregnancy?_____
Any medications taken during pregnancy and/or labour?_____
Any nausea and vomiting during pregnancy?_____
Any bleeding during pregnancy?_____
Any traumas and/or significant stress (mental, emotional or physical) during pregnancy?_____
_____
Was the pregnancy planned?_____
History of previous miscarriages? (provide dates and length of pregnancies)_____

Provide details on all of the following during pregnancy:

	(x)	Details
Alcohol Consumption		
Cigarette Use		
Recreational Drug Use		
Cravings		
Dietary Supplements		
Exercise		

List all pre-natal care including all classes:

_____

_____

NATAL HISTORY:

Any complications at birth?_____

Vaginal birth / Caesarian Section (Please circle)

Any forceps, suction or other medical instruments used?_____

Birth weight:_____(lbs/kg) Length:_____(inches/cm) APGAR score:_____

Any history of jaundice?_____ If yes, how long after birth?_____

Was the child breastfed?_____ If yes, for how long? _____

List all formulas and duration of use: _____

_____

_____

DEVELOPMENT:

Milestones	*Age (in months)*	*Details*
Crawling		
First words		
Talking in sentences		
Walking		
Teething		

FAMILY SOCIAL HISTORY:

With whom does the patient live with at this time? _____

Have the patient's parents ever married? _____

Are the parents divorced or separated? _____

Is there any significant information about the parents' relationship that could be important to the treatment of the patient? If Yes, please outline _____

_____

_____

PATIENT'S MOTHER:

Name:_____ Age:_____

Occupation and place of employment (if applicable): _____

Is the patient currently living with this parent? Y -- N

Is there any significant information, unusual, or stressful about the patient's relationship with this parent? If yes, please outline: _____
_____
Is the patient disciplined by this parent? _____
For what reasons is the patient disciplined? _____
_____
_____

PATIENT'S FATHER:
Name:_____ Age:_____
Occupation and place of employment (if applicable): _____
Is the patient currently living with this parent? Y -- N
Is there any significant information, unusual, or stressful about the patient's relationship with this parent? If yes, please outline: _____
_____

PATIENT'S SIBLINGS:

Name of sibling	*Age*	*Gender*		*Lives*		*Quality of relationship*		
		F	*M*	*Home*	*Away*	*Poor*	*Average*	*Excellent*

Other Persons Living in the Home:

Name	*Relationship*	*Quality of relationship*		
	Ex: cousin, foster child, friend	*Poor*	*Average*	*Excellent*

Comments:_____
_____

DATE OF RECENT EXAMINATIONS:
Physical: _____
Dental: _____
Vision: _____
Hearing: _____
Other (if applicable): _____
_____

Thank you.