Dr. Mirjana Baspaly ND
Naturopathic Doctor
Anmore Health And Wellness
3025 Anmore Creek Way, Anmore, BC V3H5G6
Tel: (778) 885-2153 Email: drbaspaly@naturopathicdr.ca
www.naturopathicdr.ca

Confidential Pediatric/Adolescent Case History

First Name:_____ Last Name:_____ Date:_____

Street Address:_____ City:_____

Province:_____ Postal Code:_____ Home phone: _____Cell Phone:_____

Date of Birth:_____ Age_____ Place of Birth_____ Sex _____

PHN: (Care Card Number) _____

Parent(s) Contact:
Name: _____ Home phone: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

How did you hear about the clinic?_____

I understand and agree that I am financially responsible for all charges and payment must be made at the time of visit unless other arrangements are made in advance. I understand and agree that I will pay a fee for the doctor's time if I fail to cancel or reschedule an appointment without 24 hours notice.
Patient's Signature_____ Date_____

In your opinion, what are you child's main health concerns, in order of importance?

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

Please list your child's medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____

Any other medications: _____

Please list any supplements that your child takes:

_____

_____

Please list any of the following:

Medication: Allergies _____ Sensitivities:_____
Environmental: Allergies: _____ Sensitivities:_____
Food: Allergies _____ Sensitivities:_____

Childhood illnesses:

__ scarlet fever __ rheumatic fever __ strep throat __ pneumonia
__ mononucleosis __ ear infection(s) __ tonsillitis __ rubella
__ chicken pox __ red measles __ mumps __ other_____

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

_____
_____
_____

Prenatal/birth/neonatal history:

Birth weight_____ ___ premature ___ late ___ full term
Place of child's birth: _____

Mother's health during pregnancy:

Age: _____

__ bleeding __ toxemia __ x-rays __ medications
__ drugs __ alcohol __ cigarettes __ stress
__ high blood pressure __ extreme nausea __ trauma / injury __ illness
__ heavy metal exposure __ vitamin deficiency __ diabetes __ STD
__ other_____

Family History

(Please tick off relevant boxes)

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type) _____	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Attack/stroke	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Asthma/allergies	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
TB (tuberculosis)	☐	☐	☐	☐	☐	☐
Auto-immune disease	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Extra notes: _____

_____

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Diet:

Appetite Good?: Y N P
Food cravings: _____
Foods that don't sit well:_____
List any foods child avoids: _____
Sample daily diet of child including liquids:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Drinks _____

Toxin Exposure:

Did child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____
Have child ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____
Is child particularly sensitive to perfumes, gasoline, or other vapors?:_____
Do you use pesticides, herbicides, other chemicals around your home? _____

Patient's Health History:

	Now	Past	Never		Now	Past	Never
Allergies	____	____	_____	Arthritis (juvenile)	____	____	_____
Diabetes	____	____	_____	Epilepsy	____	____	_____
Hearing loss	____	____	_____	Mental illness	____	____	_____
Anemia	____	____	_____	Asthma	____	____	_____
Bedwetting	____	____	_____	Birth defects	____	____	_____
Colic	____	____	_____	Cough/wheeze	____	____	_____
Croup	____	____	_____	Depression	____	____	_____
Diarrhea	____	____	_____	Constipation	____	____	_____
Dry skin	____	____	_____	Eczema/rash	____	____	_____
Earache/infection	____	____	_____	Frequent colds	____	____	_____
Fatigue	____	____	_____	Autistic	____	____	_____
Frequent infections	____	____	_____	Headaches	____	____	_____
Heart murmur	____	____	_____	High fever	____	____	_____
Hyperactivity	____	____	_____	Insomnia	____	____	_____
Jaundice	____	____	_____	Learning problems	____	____	_____
Moodiness	____	____	_____	Stuffy nose	____	____	_____
Thrush	____	____	_____	Vomiting spells	____	____	_____

Others: please list:_____
_____