

**Dr Serenity Aberdour  
Naturopathic Physician**

**PEDIATRIC PATIENT INFORMATION AND HEALTH HISTORY**

Name\_\_\_\_\_ Age\_\_\_\_ Birthdate\_\_\_\_\_ M F  
Today's date\_\_\_\_\_

Parents names \_\_\_\_\_

Address\_\_\_\_\_ City\_\_\_\_\_ Province\_\_\_\_\_

Postal Code\_\_\_\_\_

Home phone\_\_\_\_\_ Work phone(parent)\_\_\_\_\_

Fax\_\_\_\_\_ Email(parent)\_\_\_\_\_

Emergency Contact: Name\_\_\_\_\_ Relation\_\_\_\_\_

Emergency number\_\_\_\_\_

How did you learn about this clinic?\_\_\_\_\_

Has your child had previous treatment by a naturopathic doctor? **Y N**

If yes when?\_\_\_\_\_

Other Health Care providers:

MD/pediatrician\_\_\_\_\_

DC (chiropractor)\_\_\_\_\_

Other(s)\_\_\_\_\_

**MAIN HEALTH CONCERNS**

Please list your child's major health concerns at this time

1)\_\_\_\_\_2)\_\_\_\_\_3)\_\_\_\_\_

4)\_\_\_\_\_

When did these complaints

begin?\_\_\_\_\_

What other treatment(s) has your child received for these  
complaints?\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have any specialists been consulted regarding these complaints? **Y N**

Please list your child's current prescription medications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## HEALTH HISTORY

Please list all prescription medication that your child has used in the last 2 years

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Please list all non-prescription medications that your child currently uses (include all over the counter products, vitamins, minerals, herbal medicines and other remedies)

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Please list any known allergies to

1) Medications \_\_\_\_\_

2) Foods \_\_\_\_\_

3) Plants/environment/animals \_\_\_\_\_

\_\_\_\_\_

Please list any major illnesses/injuries/ surgeries/hospitalisations and their approximate dates: \_\_\_\_\_

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Please list vaccinations received: \_\_\_\_\_

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Were there any complications during pregnancy or delivery of this child?

Do one/both of child's parents (or caregivers) smoke? **Y** **N**

Was the child breast fed? **Y** **N**

If so, at what age was child weaned? \_\_\_\_\_

Child's APGAR score at birth \_\_\_\_\_

Child's birth weight \_\_\_\_\_

Please indicate which, if any, of the following complaints your child has had:

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Confusion     | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Ear infections       |
| <input type="checkbox"/> Cold sores  | <input type="checkbox"/> Depression    | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Colic       |  |   |

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Frequent infections   | <input type="checkbox"/> Muscle or joint pain            | <input type="checkbox"/> Strep throat             |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Nausea/vomiting                 | <input type="checkbox"/> Sunstroke                |
| <input type="checkbox"/> Hives                 | <input type="checkbox"/> Recurring fevers                | <input type="checkbox"/> Tonsillitis              |
|  | <input type="checkbox"/> Scarlet fever                   | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Seizures                        | <input type="checkbox"/> Warts                    |
| <input type="checkbox"/> Measles               | <input type="checkbox"/> Skin problems (please specify): | <input type="checkbox"/> Worms                    |
| <input type="checkbox"/> Mononucleosis         |  | <input type="checkbox"/> Whooping cough           |
| <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Sleep problems                  |   |

Please note family members who do/have had any of the following complaints

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Osteoporosis                                    |
| <input type="checkbox"/> Allergies                                | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> Thyroid disease                                 |
| <input type="checkbox"/> Depression                               | <input type="checkbox"/> Kidney disease                                  |
| <input type="checkbox"/> Other mental disorders (please specify): | <input type="checkbox"/> Lung disease                                    |
|   | <input type="checkbox"/> Chronic digestive tract complaints or disease   |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Substance abuse/addiction                       |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Other major illness/ disorder (please specify): |
| <input type="checkbox"/> Heart disease                            |  |

**Diet**

Please describe your child's typical daily food and fluid intake and approximate amounts:

Are you currently following a specialized/ restricted diet with this child?

**Additional Information:**

Please add any additional information about your child and/or her/his health that you feel is important (use reverse side of page if needed)