DR. STEPHANIE PELTZ, ND

Confidential Pediatric/Adolescent Case History

Please fill in the following form to the best of your ability. If you have questions, please make a note.

Name: _____Date: _____
Address: _____City: _____
Postal Code:_____ Date of birth ____/____/_____ Age _____ Sex: M / F
(m) (d) (yr)
PHN: (Care Card Number) _____

Parent(s) Contact:
Name: _____
Home #: _____ Work #: _____ Cell #:_____
Name: _____
Home #: _____ Work #: _____ Cell #:_____
How did you hear about Dr. Peltz?_____
Email Address: _____
(for receipts, handouts and newsletters. This information will never be sold, or shared)
Would you like to receive a quarterly electronic newsletter? Y / N (please circle)

Please list your main health concerns in order of importance:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other	_____	_____

Childhood illnesses:

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

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

Prenatal/birth/neonatal history:
Birth weight_____ ___ premature ___ late ___ full term

Mother's health during pregnancy:

__ age	__ bleeding	__ extreme nausea
__ illness	__ toxemia	__ trauma / injury
__ stress	__ x-rays	__ high blood pressure
__ diabetes	__ medications	__ cigarettes
__ alcohol	__ drugs	__ other_____

Place of birth_____

Infant feeding:
__ breast fed: if yes, how long?_____
__ formula fed: how long and types of formula?_____
Age solids began:_____ What foods?_____
Food allergy/intolerance(s)_____
Favourite foods:_____

Sample daily diet: choose a typical day, include liquids
_____
_____
_____
_____
_____

Hospitalizations/surgeries/accidents/serious injuries and illnesses:
(describe each incident and give dates)
_____
_____
_____
_____

Family History
Identify all family members who have or have had any of the following:

___	_____ alcoholism	___	_____ allergies
___	_____ anemia	___	_____ arthritis
___	_____ asthma	___	_____ diabetes
___	_____ eczema	___	_____ epilepsy
___	_____ heart disease	___	_____ hearing loss
___	_____hypoglycemia	___	_____ mental illness
___	_____ obesity	___	_____ stroke
___	_____ thyroid disorder	___	_____ other(s)

Patient's Health History

Now	Past	Never		Now	Past	Never	
____	____	_____	allergies	____	____	_____	fatigue
____	____	_____	anemia	____	____	_____	frequent infections
____	____	_____	asthma	____	____	_____	headaches
____	____	_____	bedwetting	____	____	_____	heart murmur
____	____	_____	birth defects	____	____	_____	high fever
____	____	_____	colic	____	____	_____	hyperactivity
____	____	_____	cough/wheeze	____	____	_____	insomnia
____	____	_____	croup	____	____	_____	jaundice
____	____	_____	depression	____	____	_____	learning problem
____	____	_____	diarrhea	____	____	_____	moodiness
____	____	_____	dry skin	____	____	_____	stuffy nose
____	____	_____	earache(s)	____	____	_____	thrush
____	____	_____	eczema/rash	____	____	_____	vomiting spells

others:
please list:_____
_____

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CONSENT FORM

Dear patients:
Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, craniosacral therapy, clinical nutritional, lifestyle counselling, and intravenous nutritional therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee of the full cost of my missed visit will be applied. I understand that I am responsible for payment at the time services are rendered. Dispensary items must be paid for in full before leaving the office.

Signature x_____ Date x_____

Doctor's Signature x_____ Date x_____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x_____ Date x_____

Welcome!

Thank you for filling out this extensive questionnaire.

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