



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:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> mononucleosis |
| <input type="checkbox"/> red measles | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> ear infection(s) |
| <input type="checkbox"/> mumps | <input type="checkbox"/> strep throat | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> rubella | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other _____ |

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: _____

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.