



#103 - 565 17<sup>th</sup> Street · West Vancouver BC · V7V 3S9  
 Phone: 604 - 925 - 2560  
 www.westvanwellness.com

### Confidential Pediatric Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Parent(s) Contact: Name(s) \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

Preferred method of communication: Home Phone  Cell Phone  Email

How did you find out about our clinic? \_\_\_\_\_

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	___ scarlet fever	___ mononucleosis
___ red measles	___ rheumatic fever	___ ear infection(s)
___ mumps	___ strep throat	___ tonsillitis
___ rubella	___ pneumonia	___ 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_