

Dr. Peter Bennett
Meditrine Naturopathic Medical Clinic

Dr. Stephanie Trenciansky

PEDIATRIC/ADOLESCENT HISTORY FORM

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

PATIENT'S FULL NAME _____ AGE _____ SEX _____ BIRTHDATE _____ / _____ / _____
 NAME YOU PREFER TO BE CALLED _____ PARENT'S NAMES _____
 ADDRESS _____ CITY _____ POSTAL CODE _____
 HOME PHONE _____ PARENT'S WORK PHONE _____ (mother, father, other)
 PARENT'S EMAIL ADDRESS _____ FAMILY PHYSICIAN _____
 CHIROPRACTOR _____ SPECIALIST _____
 WHO REFERRED YOU TO THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS/ PROBLEMS

MEDICATIONS:

SUPPLEMENTS:

ALLERGIES:(medications, pollens, animals, food)

	Now	Past	Frequency		Now	Past	Frequency	
ASPIRIN	___	___	___	VITAMINS	___	___	___	
TYLENOL	___	___	___	MINERALS	___	___	___	
ANTIBIOTICS	___	___	___	FLUORIDE	___	___	___	
DECONGESTANTS	___	___	___	HERBS	___	___	___	
_____	___	___	___	_____	___	___	___	

CHILDHOOD ILLNESSES:

IMMUNIZATIONS: (age given, any adverse reactions?)

___ CHICKEN POX	___ SCARLET FEVER	___ MONONUCLEOSIS	___ DPT (Diphtheria, Pertussis, Tetanus)
___ MEASLES	___ RHEUMATIC FEVER	___ EAR INFECTIONS	___ MMR (Measles, Mumps, rubella)
___ MUMPS	___ STREP THROAT	___ TONSILLITIS	___ POLIO
___ RUBELLA	___ PNEUMONIA	___ OTHER _____	___ HAEMOPHILUS INFLUENZA type B (Meningitis)
			___ HEP-B (Hepatitis B)

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never		Now	Past	Never	
ACNE	___	___	___	EPILEPSY/SEIZURES	___	___	___	SURGERIES (YEAR & TYPE)
ALLERGIES	___	___	___	FATIGUE	___	___	___	_____
ANEMIA	___	___	___	FREQUENT INFECTION	___	___	___	_____
ASTHMA	___	___	___	HEADACHES	___	___	___	_____
BED WETTING	___	___	___	HEART MURMUR	___	___	___	_____
BIRTH DEFECTS	___	___	___	HIGH FEVER	___	___	___	HOSPITALIZATIONS (YEAR)
COLIC	___	___	___	HYPERACTIVITY	___	___	___	_____
CONSTIPATION	___	___	___	INSOMNIA	___	___	___	_____
COUGH/WHEEZE	___	___	___	JAUNDICE	___	___	___	_____
CRADLE CAP	___	___	___	LEARNING DISORDER	___	___	___	_____
DEPRESSION	___	___	___	MOODINESS	___	___	___	INJURES/ACCIDENTS (YEAR)
DIARRHEA	___	___	___	STUFFY NOSE	___	___	___	_____
DIZZY SPELLS	___	___	___	THRUSH	___	___	___	_____
EARACHES	___	___	___	VOMITING SPELLS	___	___	___	_____
ECZEMA	___	___	___	OTHER _____	___	___	___	OTHER CONDITIONS _____
EXPOSURE TO:								_____
CIGRETTE SMOKE	___	___	___					_____

WHAT IS YOUR INFANT'S/ CHILDS/ ADOLESCENT'S DISPOSTION?

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____		MOTHER (age)* _____		BROTHERS (ages)* _____		SISTERS (ages)* _____	
*If deceased, Please list age at death and circle.							
IDENTIFY ALL FAMILY MEMEBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1,B2,S1 ETC.)							
___ ALCOHOLISM	___ BLEEDING DISORDER	___ HEART DISEASE	___ OBESITY	___ ALLERGIES	___ CANCER of _____	___ HEARING LOSS	___ STOMACH ULCERS
___ ANEMIA	___ COLITIS	___ HIGH BLOOD PRESSURE	___ STROKE	___ ARTHRITIS	___ DIABETES	___ HYPOGLYCEMIA	___ THYROID DISORDER
___ ASTHMA	___ ECZEMA	___ KIDNEY DISEASE	___ TUBERCULOSIS	___ BIRTH DEFECTS	___ EPILEPSY	___ MENTAL ILLNESS	___ OTHER _____
DOES THE PATIENT HAVE ANY OF THE ABOVE? _____							
IF YES, WHICH ONES? _____							

PRENATAL/ BIRTH/ FEEDING HISTORY:

1. MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

___ AGE	___ TRAUMA/INJURY	___ ALCOHOL CONSUMPTION	___ OTHER _____
___ BLEEDING	___ STRESS	___ DRUGS	___ TOXEMIA
___ NAUSEA	___ HIGH BLOOD PRESSURE	___ SMOKING	
___ ILLNESS	___ X-RAYS	___ MEDICATIONS _____	

2. TERM _____ PREMATURE _____ FULL _____ BIRTH WEIGHT _____

3. WAS PREGNANCY/BIRTH _____ EASY _____ DIFFICULT _____ C-SECTION? _____

4. FEEDING OF INFANT

BREAST FED _____	HOW LONG? _____	COW'S MILK? _____
FORMULA FED _____	HOW LONG? _____	TYPE OF FORMULA _____
AGE SOLID FOODS BEGUN _____		WHAT FOODS? _____
ANY FOOD ALLERGIES OR INTOLERANCES? _____		TO WHAT FOODS? _____

5. SAMPLE DAILY DIET (Choose a typical day and include foods and liquids)

6. PERVIOUS PREGNANCIES BY NATURAL MOTHER AND ANY COMPLICATIONS

SOCIAL HISTORY

1.	PARENTS: _____ MARRIED _____ SEPERATED _____ DIVORCED
	MOTHER'S OCCUPATION _____ FULL TIME _____ PART TIME
	FATHER'S OCCUPATION _____ FULL TIME _____ PART TIME
2.	OTHER GUARDIAN: _____ RELATIONSHIP _____
3.	OTHERS RESIDING IN HOME _____ RELATIONSHIP _____
4.	DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS A DAY? _____ # OF DAYS A WEEK _____
5.	INTERACTION WITH RELATIVES: WHO? _____ HOW OFTEN _____

DO YOU HAVE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

MEDITRINE NATUROPATHIC MEDICAL CLINIC

The doctors and staff at our clinic welcome you!

Meditrine Naturopathic Medical Clinic fees are as follows for both doctors: * not including HST.

First Office Visit (30-45 mins.)	\$ 95.00
Pediatric First Office Visit, 12 yrs & under (30-45mins)	\$ 85.00
Return Office Visit (15-30 mins)	\$ 68.00
Brief Office Visit (10-15 mins.)	\$ 42.00
Extended Office Visit (45-60 mins.)	\$ 127.00
Physical & Pap (30-45 mins.)	\$ 100.00
Food Allergy Test	\$ 105.00
Food Allergy Retest	\$ 45.00
Blood Typing	\$ 15.00

There's a **full charge fee** for missed doctor visits or for those rescheduled/cancelled with less than 24 hours notice & an additional fee of \$40 for any missed allergy test/retest. Please remember, with less than 24 hours notice, it's difficult for others to come and fill your vacant appointment time.

Fees for office visits, laboratory services and medicine items are due at the time of service.

Most extended medical plans provide coverage for visits, lab and food allergy tests. Please save your receipts for this extended coverage, as we will not be able to issue another receipt. A \$10.00 charge will apply for extended reports.

Custom made or special order medicines are to be paid for before they are ordered or made. There are also no rebates on quantity of medicine items ordered.

Any natural hormone alternatives, that you may be prescribed, are refillable only under doctor authorization; otherwise a follow-up visit is required. This is a mandatory clinic policy.

Please be aware that at times prices for medicines may decrease, increase or stay the same. This reflects exact current pricing that we are charged by our suppliers and US exchange rates.

I have read the above and agree to comply with the terms stated above.

Signature _____

Date _____

Enjoy Your Visit!
Drs. Stephanie & Peter