Optimum
Integrative Health Centre

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Redefine Your Health!

Confidential Pediatric Case History

Name: ______________________________________ Date: _______________________

Address: ____

Town/City: ____________________________ Postal Code: ________________________

Home #: _________________ Cell #: _________________

Date of Birth: ________________ Age: _____ Sex: Male Female

OHIP #: ____

Parent Contact:

Name: ____

Address: ____

Town/City: ____________________________ Postal Code: ________________________

Home #: ________________ Work #: _________________ Cell #: _________________

Email Address: ____

Check if you do not want to receive our free newsletter.

Parent Contact:

Name: ____

Address: ____

Town/City: ____________________________ Postal Code: ________________________

Home #: _________________ Work #: _________________ Cell #: _________________

Email Address: ____

How did you hear about us? ____

Names of Other Healthcare Providers:

- Medical/Family Doctor: ____
- Naturopathic Doctor: ____
- Specialist: ____
- Other: ____

List your main health concerns in order of importance:

1. _____________________________ 4. _____________________________

2. _____________________________ 5. _____________________________

3. _____________________________ 6. _____________________________

Past Medical History

Please check and date (year) if any of these apply to you.

Prenatal/birth/neonatal history: Birth weight: ____________

Premature Full term Late

Mother's health during pregnancy:

Age_____	Extreme nausea	Trauma / injury
Alcohol	High blood pressure	X-rays
Bleeding	Illness	Other____________
Cigarettes	Medications	_________________
Diabetes	Stress	
Drugs	Toxemia	

Infant feeding:

Breast fed	Duration: ________	
Formula fed	Duration: ________	Type: ___________

Age solids began: _________

What foods? ____

Food allergy/intolerance(s): ____

Favourite foods: ____

Childhood illnesses:

Chicken pox	Red measles	Strep throat
Ear infection(s)	Rheumatic fever	Tonsillitis
Mononucleosis		Other__________
Mumps	Rubella	_______________
Pneumonia	Scarlet fever	

Immunizations: List types, age given, and any reactions:

____

____

____

Surgeries, Hospitalizations, Accidents, Serious Injuries: _________________________________

Other: ____

Current History

Height: ___________ Weight: ___________ Max Weight: __________

Do you currently use any of the following frequently [more than once a week]?

Aspirin	Ibuprofen
Tylenol	Antibiotics

Exercise: Types _____________________ Duration ___________ Frequency ____________

Allergies (drug, food, environmental): ____

Diet: List any food groups that you avoid ____

Are you currently taking any medications or supplements? If so, please list all with dosing:

____

____

FAMILY HISTORY *Please check if any of these apply to you or your family.*

Alcoholism	Depression	Hives	Thyroid
Allergies	Diabetes	Kidney disease	Disease
Anemia	Epilepsy	Mental Illness	Tuberculosis
Arthritis	Hay fever	Obesity	Other________
Asthma	Heart disease	Schizophrenia	____________
Cancer	High blood	Seizures	
Dementia	pressure	Stroke	

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:

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OTHER

Is there anything else that you feel is important that has not been covered above?

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