

NEW PATIENT REGISTRATION-PEDIATRICS

Sean Ceaser, ND
Naturopathic Physician

Date: _____

Name: _____

Mailing Address: _____ Apt#: _____

City: _____ Province: _____ Postal code: _____

Family telephone #: Home: _____ Work: _____

Cell: _____ email: _____

Age: _____ Sex: M / F Date of Birth: _____

Parent's names: _____

Medical doctor: _____

Phone # _____

Other health practitioners involved in care:

_____ Phone # _____

_____ Phone # _____

Emergency phone contact:

_____ Phone # _____

Does the child have private insurance that covers Naturopathic Medicine? Yes No

Does insurance cover Naturopathic Labs (Call provider)? Yes No

Insurance provider _____ Limit of coverage \$ _____

Is insurance through a work plan? Yes No

How did you hear about the clinic? _____

MEDICAL HISTORY QUESTIONNAIRE

Please list the reasons for this visit in order of importance:

1.

2.

3.

Y=yes, currently

N=never

P=yes, in the past, list age and details

SKIN.

Y N P Please list the reasons for your visit above

Y	N	P	Color changes	Y	N	P	Eczema/Psoriasis
Y	N	P	Hives	Y	N	P	Itching
Y	N	P	Lumps	Y	N	P	Moles
Y	N	P	Rashes	Y	N	P	Scaling, flaking
Y	N	P	Jaundice	Y	N	P	Tingling sensation
Y	N	P	Acne	Y	N	P	Boils

HEAD.

Y	N	P	Skull fracture	Y	N	P	Headaches
Y	N	P	Head injury	Y	N	P	Other:

EYES.

Y	N	P	Eye pain	Y	N	P	Double vision
Y	N	P	Itchy, red	Y	N	P	Tearing, watery
Y	N	P	Glasses	Y	N	P	Impaired vision
Y	N	P	Sensitive to light	Y	N	P	Vision- flashes

EARS.

Y	N	P	Ear infections	Y	N	P	Earaches
Y	N	P	Discharges	Y	N	P	Hearing difficulty
Y	N	P	Ringing	Y	N	P	Ear trauma
Y	N	P	Itching	Y	N	P	Dizziness

NOSE AND SINUSES.

Y	N	P	Frequent colds	Y	N	P	Hay fever
Y	N	P	Nose bleeds	Y	N	P	Sinus pain
Y	N	P	Loss of smell	Y	N	P	Runny nose
Y	N	P	Stiffness	Y	N	P	Other:

NECK.

Y	N	P	Swollen glands	Y	N	P	Trauma
Y	N	P	Pain, stiffness	Y	N	P	Lumps

MOUTH AND THROAT.

Y	N	P	Cavities	Y	N	P	Bleeding gums
Y	N	P	Hoarse	Y	N	P	Difficulty swallowing
Y	N	P	Canker sores	Y	N	P	Freq. sore throats
Y	N	P	Loss of taste	Y	N	P	Metal taste in mouth
Y	N	P	Sore tongue	Y	N	P	Speech problems

EXTREMITIES.

Y	N	P	Leg pains	Y	N	P	Broken bones
Y	N	P	Swollen joints	Y	N	P	Muscle cramps
Y	N	P	Restless legs	Y	N	P	Weakness
Y	N	P	Cold hands, feet	Y	N	P	Numbness or tingling

GASTROINTESTINAL AND URINARY.

Y	N	P	Belching, bloating, gas	Y	N	P	Blood in stool
Y	N	P	Change in appetite	Y	N	P	Mucus in stool
Y	N	P	Change in thirst	Y	N	P	Binge eating
Y	N	P	Constipation	Y	N	P	Diarrhea
Y	N	P	Pain in belly	Y	N	P	Vomiting
Y	N	P	Bladder infection	Y	N	P	Bed wetting

Frequency of bowel movements a day?

Frequency of urination a day?

RESPIRATORY.

Y	N	P	Asthma	Y	N	P	Bronchitis
Y	N	P	Seasonal allergy	Y	N	P	Cough blood
Y	N	P	Hard to breathe	Y	N	P	Cough
Y	N	P	Short of breath	Y	N	P	Pneumonia
Y	N	P	Wheezing	Y	N	P	Other:

ENDOCRINE, BLOOD, IMMUNE SYSTEM

Y	N	P	Shaky before a meal	Y	N	P	Sugar cravings
Y	N	P	Irritable before meals	Y	N	P	Easy bleeding
Y	N	P	Headaches before meals	Y	N	P	Chronic fatigue
Y	N	P	Tired after lunch	Y	N	P	Easy bruising
Y	N	P	Excessive hunger	Y	N	P	Better after meal
Y	N	P	Excessive thirst	Y	N	P	Anemia
Y	N	P	Excessive urination	Y	N	P	Mononucleosis
Y	N	P	Confusion before meals	Y	N	P	AM fatigue

NEUROLOGICAL.

Y	N	P	Dizziness	Y	N	P	Numbness/tingling
Y	N	P	Fainting	Y	N	P	Memory loss
Y	N	P	Seizures	Y	N	P	Paralysis

MENTAL AND EMOTIONAL.

Y	N	P	Irritability	Y	N	P	Fatigue
Y	N	P	Impaired memory	Y	N	P	Suicidal
Y	N	P	Depression	Y	N	P	Mood swings
Y	N	P	Excessive anger	Y	N	P	Weeping
Y	N	P	Excessive fears	Y	N	P	Compulsions
Y	N	P	Confusion	Y	N	P	Anxiety, panic

SLEEP AND DREAMS.

Y	N	P	Insomnia	Y	N	P	Drowsiness
Y	N	P	Troubles falling asleep	Y	N	P	Nightmares
Y	N	P	Frequent waking	Y	N	P	Grinding teeth
Y	N	P	Night sweats	Y	N	P	Unrefreshed in morning

How many hours does child sleep?

BIRTH & DEVELOPMENTAL HISTORY.

Full term, premature, late	_____	Weight at birth	_____		
Length of labor	_____	Complications	_____		
Y	N	Breast fed	Months _____		
Y	N	Colic	Y	N	Diarrhea
Y	N	Birth injuries	Y	N	Birth defects
Y	N	Seizures	Y	N	Blue baby
Y	N	Rashes	Y	N	Jaundice
Y	N	Cerebral Palsy	Y	N	Other
Solid food	Age _____	Sitting up	Age _____		
Crawling	Age _____	Walking	Age _____		

MOTHER'S HEALTH DURING PREGNANCY.

Mother's age at child's birth	_____	Previous pregnancies, miscarriages	_____		
Y	N	Bleeding	Y	N	Nausea
Y	N	Medications	_____		
Y	N	Cigarettes/ drugs	How many/ day _____		
Y	N	Alcohol	Now much _____		
Y	N	High blood pressure	Y	N	Gestational diabetes
Y	N	Thyroid Problems	Y	N	Other

NUTRITION AND DIET.

Y	N	P	Gain weight easily	Y	N	P	Overweight
Y	N	P	Underweight	Y	N	P	Other
Height _____				Weight in office: _____ lbs.			
Water intake: _____ glasses/day				_____ kgs.			

DRINKS AND DRUGS.

Y	N	P	Soft drinks	How much?
Y	N	P	Other liquids	How much?

Family history: Please list family member and details, eg. mother, skin cancer.

Y	N	Alcoholism	Y	N	Hepatitis
Y	N	AIDS	Y	N	Herpes
Y	N	Allergies	Y	N	High blood pressure
Y	N	Arthritis	Y	N	Insomnia
Y	N	Asthma, hay fever	Y	N	Kidney problems
Y	N	Cancer	Y	N	Mental illness
Y	N	Chronic fatigue	Y	N	Osteoporosis
Y	N	Depression	Y	N	Stroke
Y	N	Diabetes	Y	N	Syphilis
Y	N	Drug addiction	Y	N	Tuberculosis
Y	N	Eczema, Psoriasis	Y	N	Thyroid problems
Y	N	Epilepsy	Y	N	Warts, severe
Y	N	Glaucoma	Y	N	Other
Y	N	Gonorrhea	Y	N	Other
Y	N	Heart disease	Y	N	Other

IMMUNIZATIONS.

Y	N	Mumps	Y	N	Measles	Y	N	Rubella
Y	N	Diphtheria	Y	N	Pertussis	Y	N	Tetanus
Y	N	Hepatitis	Y	N	Polio	Y	N	TB
Y	N	Rabies	Y	N	Smallpox	Y	N	Typhoid
Y	N	Flu	Y	N	Meningococcus	Y	N	Typhus

Was there a reaction to any of the above immunizations?

ALLERGIES.

Drug allergies? Y N. Please list:
 Environmental allergies? Y N Please list:
 Foods allergies? Y N. Please list:

HOSPITALIZATION AND SURGERIES. Please list age, purpose and treatment:

CURRENT MEDICATIONS. Include medications, vitamins, supplements, herbs, over-the-counter drugs. Also list the dosage or amount used and when they were begun:

Medicine:	Dose:	Began on:	Stopped on:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

Number of courses of antibiotics taken in lifetime? _____

For what? _____

When was the last course? _____

Has the child ever traveled to a foreign country? If so, to where and when. Did they get ill?

HOMEOPATHY

Please circle:

I am: thirsty not thirsty

Prefer: ice cold cool warm hot drinks

Crave what foods?

Any fears? Of what?

Body temperature is hot/ warm/ cool/ chilly (circle one)

Worst time of day or night?

What is the best time of day?

Dominant emotion:

Past homeopathic remedies taken:

Please list major occurrences in your child's life.

Event:

How child responded:

Age:
