



## Inspired Health Naturopathic Clinic

385 Lagoon Road Colwood, BC V9C 1T5 Phone: (250) 478-4734

Dr. Trevorrow and her staff are delighted to welcome your family to our clinic! Please fill out the following personal information and health history to give us the best picture possible of your child's concerns.

### Personal Information (please print):

Child's Name: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_

Parent(s) Name (s): \_\_\_\_\_

Address: \_\_\_\_\_

Address of 2nd parent (if different): \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_ Postal code: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work-parent): \_\_\_\_\_

Alternate phone: \_\_\_\_\_

Email address: \_\_\_\_\_ May we correspond with you by email? Y N

Child's birth date: \_\_\_\_\_ Gender: M F

Parent's occupation(s): \_\_\_\_\_

Are there other family members seen here? \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Work phone no.: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Home phone no.: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Note: Please bring a recent picture of your child that we may keep plus a baby picture that we may look at and return—thanks!

**Child's Medical Information:**

Current General Practitioner (MD): \_\_\_\_\_  none at present

GP address/phone: \_\_\_\_\_

Are you seeing a pediatrician or other medical specialist? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

Name/address/phone of specialist (if care is ongoing):  
\_\_\_\_\_

Diagnoses or explanation(s) given to you about your child (Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_)  
(m/d/y):  
\_\_\_\_\_  
\_\_\_\_\_

What questions do you have that you would like answered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of help would you like to be provided? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby consent to treatment by the practitioners of Inspired Health Clinic. I understand that I am responsible for any treatment and pharmacy costs at the time of my visit. I also understand that I am responsible for paying a \$25.00 fee if I do not give 24 hours' notice of cancellation.

Signature: \_\_\_\_\_ Today's date: \_\_\_\_\_

(Parent or guardian if a minor)



Allergies/sensitivities:

Is your child hypersensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental chemicals, smoke, perfume etc.? \_\_\_\_\_

Are there any foods/food groups that he/she refuses to eat? Yes \_\_\_\_\_ No \_\_\_\_\_

If 'yes', which ones? \_\_\_\_\_

**Current medications:** please list any prescription medications (from your doctor) or over the counter medications (such as aspirin, cold medicines, antacids) your child is taking:

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

Please list any supplements (vitamins/minerals/herbs etc) you are giving your child:

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

**Major injuries – Please describe and give dates:**

INJURY	DATE(S)	RESULTS

**Major surgeries (i.e. tonsils, ear tubes, etc.) – Please describe and give dates:**

SURGERY	DATE(S)	RESULTS

Illnesses-please list dates and any complications:

ILLNESS	DATE(S)	COMPLICATIONS (if any)
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Chicken pox		
Mononucleosis		
Thrush		
Other: (please list): _____ _____ _____ _____		

### Dietary/Nutritional History

Breast-fed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long? \_\_\_\_\_

If bottle-fed, what type/brand of formula? \_\_\_\_\_

Begun at what age? \_\_\_\_\_ For how long? \_\_\_\_\_

First food introduction at what age? \_\_\_\_\_ What were they? \_\_\_\_\_

Did you give whole milk? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, begun at what age? \_\_\_\_\_

Known allergies to food? (Please list): \_\_\_\_\_

\_\_\_\_\_

Suspected sensitivities to foods? (Please list): \_\_\_\_\_

\_\_\_\_\_

Food cravings? (please list): \_\_\_\_\_

Foods my child eats (Place  in appropriate column):

Food	Daily	3-5x/week	1-3x/week	Never/almost never	Used to eat a lot but no longer does
Cookies:					

Candy:					
Sweet foods:					
Caffeinated drinks (coke, tea etc.)					
Chocolate:					
Milk: Whole:					
2%:					
1%:					
Skim:					
Cheese:					
Ice Cream:					
Salty foods:					
Meat:					
Pasta:					
Bread: White:					
Whole wheat:					
Other:					

Check (✓) the most appropriate description below of your child's diet:

\_\_\_ Mostly baby foods

\_\_\_ Mostly carbohydrates (bread, pasta etc.)

\_\_\_ Mostly dairy (milk, cheese, yogurt etc.)

\_\_\_ Mostly meat

\_\_\_ Mostly vegetarian (vegetables, fruits, grains etc.)

\_\_\_ other-describe: \_\_\_\_\_

Have you tried any special diets? Please indicate below:

now	past	Diets	Very good	Good	None	bad	Very bad	Bad then good	Comments
		Gluten free							
		Casein free							
		Yeast free							
		Feingold							
		Food avoidance							
		Other:							

Any odd/strange GI symptoms that you notice often (ie. Gas/bloating/diarrhea/constipation etc)?

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**Family Medical History:**

Is there a family history of any of the following (please circle)?

Cancer	Diabetes	Heart disease
Kidney disease	Epilepsy	High blood pressure
Tuberculosis	Stroke	High cholesterol
Asthma/hay fever/hives	Arthritis	anemia
Mood problems	Ulcers	Crohn's disease/ulcerative colitis

Any other relevant family history? \_\_\_\_\_

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Thank you for taking the time to fill out this form.