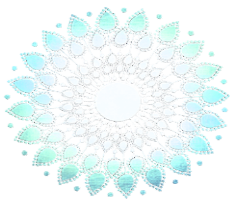

PURE Health Massage & Wellness
#220 - 12565 88th Avenue, Surrey, BC V3W 3J7
Tel: 778-592-1442

PEDIATRIC PATIENT PROFILE

DATE________________

FULL NAME ______________________________ AGE ______ BIRTHDATE _____/______/______
SEX ____________ MTH/DY/YR

ADDRESS ______________________________ PC

EMAIL ______________________________

MOTHER'S NAME ______________________________ FATHER'S NAME ____________________

PHONE # ______________________________ PREFERRED CONTACT: HOME/WORK/CELL

EMERGENCY CONTACT ______________________________ PHONE # ____________________

PRIMARY PHYSICIAN ______________________________ PHONE # ____________________

KNOWN ALLERGIES (FOOD, DRUGS, VACCINES, ENVIRONMENTAL ETC.

HOW DID YOU HEAR ABOUT THE CLINIC? ☐ Friend ☐ BCNA ☐ Internet ☐ Yellow Pages ☐ Other ____________________

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in her diagnosis and treatment. This is a confidential record and will NOT be released unless you have authorized us to do so. Thank you

PRESENT HEALTH PROBLEMS CONCERNS: Please list in the order or priority to YOU

1.
2.
3.
4.
5.

LIST OF MEDICATIONS CURRENTLY TAKING (prescription & over the counter drugs, vitamins, herbs, homeopathic remedies etc.

1.	dosage	5.	
2.	dosage	6.	
3.	dosage	7.	
4.	dosage	8.	

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES

☐ MEASLES ☐ RUBELLA ☐ MUMPS ☐ RHEUMATIC FEVER ☐ CHICKEN POX
☐ EAR INFECTIONS ☐ POLIO ☐ STREP THROAT ☐ PNEUMONIA ☐ MONONUCLEOSIS
☐ OTHER

HOSPITALIZATION (WHEN, FOR WHAT, AND HOW LONG):

ACCIDENTS AND INJURIES:

☐ **ALL IMMUNIZATIONS UP TO DATE:** DTP Diptheria, Tetanus, Pertussis; POLIO: Poliomyclitis; mmr: Measles, Mumps Rubella
☐ ALL IMMUNIZATIONS ***PLUS ADDITIONAL*** IMMUNIZATIONS, PLEASE LIST ____
☐ ALL IMUNIZATIONS UP TO DATE ***EXCEPT FOR*** : PLEASE SPECIFY ____
☐ OPTED OUT OF IMMUNIZATIONS OR IMMUNIZED FOR ONLY: PLEASE SPECIFY ____

PRENATAL/BIRTH/NEONATAL/FEEDING HISTORY

Mother's health furing pregnancy (check off or fill in appropriate ones):

☐ Nausea ☐ Took X-Rays ☐ High blood pressure ☐ Smoked ☐ Drank Alcohol ☐ Vaginal Bleeding

☐ Protein in urine ☐ High blood sugar ☐ Took Medications, *what where they?* ______________________________

AGE AT PREGNANCY ___________ AMOUNT OF WEIGHT GAIN DURING PREGNANCY ___________

BIRTH PLACE ☐ HOSPITAL ☐ HOME ☐ BIRTHING CENTRE ☐ OTHER (where) ____________________________

☐ NATURAL ☐ CAESARIAN ☐ FORCEPS *DID YOU HAVE AN EPIDURAL?* ________

OTHER COMPLICATION, EXPLAIN ____

CONDITIONS AT BIRTH (CHECK & FILL IN APPROPRIATE ONES)

WEIGHT _____ ☐ FULL TERM ☐ PREMATURE, HOW MANY WEEKS? ______

☐ LATE, HOW MANY WEEKS? _____ ☐ BREATHING PROBLEMS ☐ CYANOSIS (LOOKED BLUE)

☐ JAUNDICE ☐ ANEMIA ☐ INFECTIONS ☐ BIRTH DEFECTS, WHAT? ___________________________________

☐ OTHERS, PLEASE EXPLAIN ____

FEEDING ☐ BREAST FED, FOR HOW LONG? _________________________

☐ BOTTLE FED, STARTED WHEN? ____________ WHICH BRANDS? __________________

AT WHAT AGE (IN MONTH) WERE THESE FOOD INTRODUCED? FRUIT _____ VEGETABLES _____

GRAINS _____ WHEAT PRODUCT _____ MEAT _____ FISH _____ SEA FOODS _____

MILK _____ EGG WHITE _____ EGG YOLK _____

SOCIAL HISTORY

PARENTS: ☐ MARRIED ☐ SEPARATED ☐ COMMON LAW ☐ DIVORCED ☐ WIDOWED

ANY FAMILY MEMBER SMOKE? ☐ Y ☐ N WHO? _______________ DRINKS? ☐ N ☐ Y WHO? _______________

DAYCARE/PRESCHOOL/SCHOOL NAME: _____________________ HOW MUCH TIME PER WEEK? _______________

SIBLINGS:

	NAME	HEALTH PROBLEMS	AGE
1)			
2)			
3)			

FAMILY HISTORY

	WHO	COMMENTS
ALLERGIS		
ANEMIA		
ASTHMA		
CANCER		
DIABETES		
EPILEPSY		
HEPATITIS		
TUBERCULOSIS		
OTHER		