DR. NICOLE CERF B.Sc. ND
NATUROPATHIC PHYSICIAN

newleaf
massage & wellness

Confidential Child Health Record

Personal Information

Name ______________________ Date of first visit ______________
Address ____
City ______________ Province ____________ Postal Code ____________
Date of Birth (M/D/Y) ______________ Age _____ Gender: M F
Parents/Guardians (name) ______________________________
(home phone) ______________ (work/cell) ______________
(email address) ______________________________
Emergency contact (name) ______________ (phone) ______________
How did you hear about Dr. Cerf? ______________________________

Medical doctor (name) ______________ (phone) ______________
Medical specialist (name) ______________ (phone) ______________
Do you have extended medical Y N
Is child currently seeing a chiropractor? ________ massage therapist? ________

Health Overview

What are child's health concerns? List in order of importance.
1. ____
2. ____
3. ____

List current medications (*include dose*) ______________________________
____

List current supplements (*include brand and dose*) ______________________
____

Height ________ Weight ________ Head Circumference ________
Diet: Are there any avoided foods? ______________________________
Age began solids? ______ Which foods? ______________________
Was the patient breastfed? Y / N For how long? ______________
Was the patient supplemented with formula? Y / N Type? ______________
Water intake ______ cups/d
How many hours does child sleep/night? ______ During day? ______
Age began sitting ______ crawling ______ walking ______ talking ______
Regular activity Y / N Type ______ Duration ______ Frequency ______
Last well child exam? ______________________________
How would you describe child's temperament? ______________________

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Immunizations

___ Diphtheria ___ Whooping cough ___ Tetanus ___ MMR ___ Hep A ___ Hep B
___ H. Influenza B ___ Influenza ___ Varicella ___ Polio ___ Smallpox
___ Other (please list) ______________________________
Adverse reaction to vaccine? Y / N Describe ______________________________

Health History

List major surgeries including type and year ______________________________
____

How many times a year does child get a cold or flu? Treated with antibiotics?
____

Please list all allergies (*food and environmental*) ______________________________
____

Explain dental health (*dental visits/fillings*) ______________________________
____

Prenatal or labor complications? ______________________________
____

Family Health History (*parents, grandparents, siblings*)

___ Heart Disease ___ Diabetes ___ Hypertension ___ Cancer ___ Arthritis
___ Celiac Disease ___ TB ___ Birth abnormality ___ Allergies ___ Eczema
___ Asthma ___ ADHD ___ Autism ___ Mental Illness ___ Substance Abuse
___ Other (please list): ______________________________

Clarification of goals

What expectations do you have from this visit to our clinic?
____

What expectations do you have of me as your naturopathic physician?
____

Any other information you would like to mention? *(prental history/goals/health obstacles)*
____
____
____

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Informed Consent to Treat
I hereby consent my child to receive treatment by Dr. Nicole Cerf, ND. I understand that Dr. Nicole Cerf is a licensed Naturopathic Physician providing nutritional and lifestyle counseling, acupuncture/traditional oriental medical care, naturopathic spinal manipulations, botanical/herbal medicine, homeopathic medicine, and intravenous/intramuscular injections. I authorize Dr. Nicole Cerf, ND to perform specific procedures as deemed necessary to facilitate my child's diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue treatment at anytime.

Cancellation Policy
I understand that I am solely responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Email correspondence
Yes / No I would like to receive free newsletters from New Leaf Wellness
Yes / No Dr. Nicole Cerf, ND may correspond with me at the above email address

Signature ______________________________ Date ______________________________
(Parent or Guardian if patient is a minor)

Thank you for your time in providing this information.