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PATIENT'S NAME: _____ DATE _____

AGE _____ DATE OF BIRTH _____ GENDER: FEMALE ___ MALE ___

MOTHER'S NAME _____ FATHER'S NAME _____

ADDRESS _____ CITY _____ PROV ___ PC _____

HOME PHONE # _____ PARENT'S WORK# _____

PARENT'S E-MAIL ADDRESS (print clearly) _____

HOW DID YOU HEAR ABOUT US? _____

Name of Doctor, Hospital or Clinic where your child's medical records are kept _____

REASON FOR REFERRAL OR PRESENTING PROBLEMS _____

MEDICATIONS	NOW	PAST		NOW	PAST
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to Medicine	_____	_____

MEDICAL HISTORY

_____ Chicken Pox _____ Scarlet Fever _____ Tonsils, approx # of times _____
_____ Measles _____ Pneumonia _____ Ear infections, approx # of times _____
_____ Mumps _____ Frequent Colds _____ Other (please list) _____
_____ Rubella _____ Rheumatic Fever _____
Injuries, Surgeries, Hospitalization (please list) _____

IMMUNIZATIONS

Measles ___ Polio ___ MMR ___ Smallpox ___ Diphtheria ___ DPT ___ Tetanus ___ Influenza ___
Others (list) _____
Adverse Reactions: YES ___ No ___ What? _____

FAMILY HISTORY

Heart disease ___ Diabetes ___ Birth Defects ___ Hypertension ___ Arthritis ___ Tuberculosis ___ Cancer ___
Allergies ___ Mental Illness ___

BIRTH HISTORY

Term: Full ___ Premature ___ Late ___ Birth weight ___ Length of Labour ___ Complications: _____
Did your child have any of the following problems after birth? Birth defects ___ Birth injuries ___ Blue baby ___
Cerebral Palsy ___ Seizures ___ Jaundice ___ Colic ___ Fever ___ Rashes ___ Other _____
Sleep patterns first year: _____
Food Intolerances (if any) _____
Breast Fed? ___ How long? _____ Formula? _____ milk/soy _____
Age began: Solids _____ Sitting _____ Crawling _____ Walking _____ Talking _____