KAS-SKY
Wholistic Health Care Centre

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CHILD PATIENT RECORD

CONTACT INFORMATION

Name (surname): _____ (given): _____

Parent's Names: _____

Address: _____

Phone (home): _____ (work): _____

Email: _____ Mobile: _____

Guardian's Phone (home): _____ (work): _____

How did you hear about us: ☐ Website ☐ Yellow Pages ☐ Signage ☐ Family ☐ Friend ☐ Co-worker ☐ Live in the area

Introduced by: _____ Case recorded by: _____

PERSONAL INFORMATION

Date of Birth (year/month/day): _____ Age: _____ Sex: _____

Number of Siblings (and ages): _____

Where do you fit in?: _____

Brothers: _____

Sisters: _____

HEALTH CONCERNS

CHILD'S BIRTH HISTORY

How would you describe your pregnancy with this child? Any health issues or complications? _____

_____

_____

How close to your due date was your delivery? _____

Number of hours in labour: _____

Natural childbirth: _____

Cesarean Section: _____

Epidural Anesthesia: _____

Use of narcotic pain killers (example Demerol): _____

_____

Eye ointment applied at birth: _____

Did child require any medical intervention at birth? (example: drugs, therapies, emergency care): _____

_____

Breast fed? (how many hours between nursing, how old before weened): _____

_____

Formula fed? (type) How many hours between feedings? How old before weened? _____

_____

How old before introducing solid foods? What food was introduced? _____

_____

How would you describe baby's mood? (content, happy, colicky etc.): _____

_____

CHILDHOOD ILLNESSES EXPERIENCED

Ear Infections: _____ How often: _____

Treatment: _____

Chicken Pox: _____ Date (approx.): _____

Treatment: _____

Measles: _____ Date (approx.): _____

Treatment: _____

Rubella: _____ Date (approx.): _____

Treatment: _____

Mumps: _____ Date (approx.): _____

Treatment: _____

_____

Meningitis: _____ Date (approx.): _____

Treatment: _____

Colds/Flues: _____ Date (approx.): _____

Treatment: _____

Eczema: _____ Date (approx.): _____

Treatment: _____

Psoriasis: _____ Date (approx.): _____

Treatment: _____

Asthma: _____ Date (approx.): _____

Treatment: _____

Whooping Cough: _____ Date (approx.): _____

Treatment: _____

Other: _____ Date (approx.): _____

Treatment: _____

NOSE

Discharge: _____ Mucus Colour: _____

Stuffiness: _____ White Spots on top of Nose: _____

Injuries: _____

Frequent Picking of Nose: _____

Nose Bleeds (when, how much?): _____

MOUTH

Teething: _____ Drooling: _____

How old was child when first teething?: _____

Number of teeth at present: _____

Cavities: _____ How old on first dentist visit?: _____

Sore/Sensitive Teeth?: _____

Mouth Ulcers: _____ Cold Sores: _____

Grinding of Teeth: _____ When: _____

Clenching of Jaw: _____

Coated Tongue: _____ Foul Smelling Breath: _____

Bleeding Gums: _____

Toothpaste Used (Flouride): _____

How old when fisrt started brushing teeth?: _____

Last visit to the Dentist?: _____

AGES 0-5 YEARS

Weight at birth: _____ Present Weight: _____

Allergies (reactions): _____

_____

What is his/her temperament? (example whiny, sensitive, joyful, aggressive, imaginative, excitable, irritable, etc.): _____

_____

_____

Interaction with other children or siblings. Does child play on his/her own, or prefers mom, dad or siblings around? _____

_____

_____

HEAD

Hair loss: _____

Cradle cap: _____ Treatment: _____

Lice: _____ Treatment: _____

EYE INFECTION

Styes: _____

Pinkeye: _____

Inflammations: _____

Redness: _____

Discharge: _____

Puffiness: _____

Tearing: _____

Eyeglasses (do they need?): _____

How old was he/she when first started wearing glasses? _____

Headaches - location (example: right/left side, back of head/frontal/top) Type of headache (example, pounding, throbbing): _____

_____

_____

MALE

Circumcised: _____ Penal Rashes: _____

Treatment: _____

Undescended Testis: _____

Genital Itching: _____

FEMALE

Itching: _____

Treatment: _____

Vaginal bleed at birth: _____

Skin Tags: _____

Rashes: _____

Treatment: _____

LIMBS

Weak: _____

Tremors: _____

Lesions: _____

Bruises easily: _____

Hot or Cold Extremities: _____

Joint Pain: _____

Psoriasis: _____

Eczema: _____

Poor nail growth (brittle): _____

Nail Biting: _____

Congenital Malformations: _____

Sprains/Fractures: _____

CIRCULATION

History of Murmur: _____

Pain in stomach (doubling up, fetal position, adding pressure, holding abdomen: _____

Distended Abdomen (round shape, saucer like): _____

Umbilical Hernia: _____

Colic: _____

BOWLES

How old before being completely potty trained: _____

Stool frequency (how many times per day): _____

Type of stool (hard, soft): _____

Stool color (dark/medium/light, brown/green/yellow): _____

Constipation (how often): _____

Treatment: _____

Diaper rash: _____

Treatment: _____

Anal itching (worms?): _____

Anal pain: _____

URINARY

Currently using diapers: _____ Frequency (# of diapers daily): _____

Fully potty trained: _____ At what age: _____

Is there bed wetting problems?: _____

Frequency of bed wetting (times per week): _____

Foul odor: _____

Color: _____

Pain while urinating: _____

Burning: _____

SKIN

Lesions: _____

Red Spots: _____

Birth Marks: _____

Warts: _____

Bruises: _____

Skin Tags: _____

Eczema: _____

Psoriasis: _____

Pimples: _____

Rashes: _____

Cradle Cap: _____

Itchy Scalp: _____

Color of Nails: _____

NECK

Swollen Neck Glands: _____

Sore Neck: _____

Tonsils Removed: _____

Laryngitis: _____

Choking on Food: _____

EARS

Difficulty Hearing: _____

Wax in Ears: _____

Ear Infections: _____ When: _____

Treatment: _____

Dry Skin on Ears: _____ Rash: _____

Picks at Ears Frequently: _____

CHEST

Difficulty Breathing: _____

Wheezing: _____

Shortness of Breath: _____

Cough: _____ Type: _____ Frequency: _____

Treatment: _____

STOMACH

Appetite: _____

Type of Diet (please give example of breakfast, lunch, dinner, snacks): _____

Food Cravings (preference to sweets, salty, spicy, sour): _____

Aversion to Food: _____

Thirsty: _____

Preference of hot/cold drinks: _____

How much of each daily/weekly (water, soda pop, juice, milk, chocolate milk): _____

Daily Milk Consumption: _____

Stomach Cramps: _____

Gassy: _____

Vomiting: _____ Type: _____

Amount: _____ Frequency: _____

Blue Hands/Feet: _____

Irregular Heartbeat: _____

Heart Surgery: _____

VACINATIONS

Recent Vaccinations: _____

Reactions to Vaccinations: _____

MEDICATIONS

Asthma Puffers: _____ Frequency: _____

Antibiotics: _____

Vitamins/Minerals: _____

Cortisone Creme: _____

Prednisone: _____

Diaper Rash: _____

Skin Cream: _____

Anti-Histamines: _____

Other Medications: _____

_____

_____

YOUTHS

Do you drink alcohol: _____ How much and how often: _____

Do you use recreational drugs (street drugs): _____

How much and how often: _____

Do you use Pharmaceutical drugs (tylenol, aspirin, etc.): _____

Are you sexually active: _____ If yes at what age: _____

Do you use protective measures (example, condoms, birth control or other methods): _____

_____

History of sexually transmitted diseases (Epstein-Barr virus, gonorrhea, syphilis, mononucleosis, herpes, warts): _____

_____

_____