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**NEW PATIENT **CHILD** QUESTIONNAIRE**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

DATE OF BIRTH: (D) \_\_\_\_\_ (M) \_\_\_\_\_ (Y) \_\_\_\_\_ AGE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

HOW DID YOU HEAR ABOUT THIS CLINIC? \_\_\_\_\_

CARE CARD NUMBER: \_\_\_\_\_

**1. MAIN REASON(S) FOR ATTENDING THE CLINIC, IN ORDER OF IMPORTANCE. INDICATE WHEN THE SYMPTOMS HAVE APPEARED.**

**2. MEDICAL DOCTOR'S NAME:** \_\_\_\_\_

**3. DO YOU CONSULT OTHER HEALTH CARE PROFESSIONAL? PLEASE LIST:**

**4. PLEASE LIST DRUGS/MEDICATIONS CURRENTLY TAKEN:**

**5. PLEASE LIST DRUGS/MEDICATIONS TAKEN IN THE PAST:**

**6. PLEASE LIST ALL THE SUPPLEMENTS (VITAMINS, MINERALS ETC.) TAKEN:**

**7. WHICH OF THE FOLLOWING CONDITIONS HAS YOUR CHILD HAVE? (PLEASE CIRCLE)**

ABCESSES/ALLERGIES/ANEMIA/ARTHRITIS/ASTHMA/CANCER/CHICKEN POX<sup>1</sup>COLD SORES/DIABETES  
EPILEPSY/HAY FEVER/HEART DISEASE/HEPATITIS/HERPES/INFLUENZA/KIDNEY DISEASE/LEUKEMIA  
MALARIA/MEASLES/MONONUCLEOSIS/MUMPS/PARASITES/PLEURISY/PNEUMONIA/RECURRENT INFECTIONS  
RHEUMATIC FEVER/RUBELLA/SCARLET FEVER/SKIN DISEASE/STREP THROAT/SINUSITIS/SUNSTROKE  
TONSILITIS/WARTS/WHOOPING COUGH/WORMS

**8. HAS THE CHILD HAD ANY OTHER MAJOR CONDITION?**

**9. ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH THE CHILD HAS NEVER BEEN TOTALLY WELL SINCE OR WHICH HAVE BEEN MORE SERIOUS THAN USUAL?**

**10. PLEASE LIST ALL THE SURGERIES AND WHEN PERFORMED:**

**11. WHAT VACCINATIONS HAS YOUR CHILD HAD? ANY ADVERSE EFFECTS FROM THEM?**

**12. INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR COMPLAINTS HAVE AFFECTED THE FAMILY MEMBERS.**

INDICATE: F=FATHER, M=MOTHER, S1=SIBLING 1, S2=SIBLING 2 ETC., PGM=PATERNAL GRAND-MOTHER  
MGM=MATERNAL GRAND-MOTHER, PA=PATERNAL AUNT, PU=PATERNAL UNCLE ETC..

ALCOHOLISM\_\_\_ ALLERGIES\_\_\_ ARTHRITIS\_\_\_ ASTHMA\_\_\_ CANCER\_\_\_ DEPRESSION\_\_\_  
DIABETES\_\_\_ EPILEPSY\_\_\_ GONORRHEA\_\_\_ GOUT\_\_\_ HAYFEVER\_\_\_ HEART DISEASE\_\_\_ MENTAL  
ILLNESS\_\_\_ PARALYSIS\_\_\_ PNEUMONIA\_\_\_ SKIN DISEASE\_\_\_ SYPHILIS\_\_\_ TUBERCULOSIS\_\_\_



