Personal Information - Child

Child's name ____ Sex ________ Age _________
Child's date of birth ______________ (mm/dd/yy)

Child's address ________________________________ City _____________ Postal ________

Parents/Guardian name(s) ____

Address (if different)__________________________ City ______________ Postal _________
Phone (home)________________________________ (work)__________________________
Okay to leave a message? Yes/No

Emergency contact____________________________________Relation__________________
Phone_____________________

Siblings ____
(names & ages)

Family Dr./Pediatrician ____
Phone _________________ Address ____

Midwife/Obstetrician (child under 2) ____
Phone _________________ Address ____

What are your major health concerns?
____
____
When did this problem begin? ____
What medications are you trying? ____
What treatments have you tried? ____

Are there any other concerns about your child's health?
____
____
Have any of the above conditions been diagnosed? Y / N
If so, by whom?____
Please list any medications, past or present (including over the counter)
Taken in the past _____________________ Presently ______________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________

Pamela Thornton-Pow, B.Sc., N.D. • Doctor of Naturopathic Medicine
592 Lakeview Drive, Woodstock, Ontario, N4T 0A5
Tel. (519)539-9944 • Fax. (519)539-2050

Confidential Health History - Child

FAMILY HISTORY

What was the age of the parents of this child at the time of conception?
Mom _________ Dad __________

What was their level of health?
Mom ______________________________________ Dad ____

	Age if Living	Age at Death	Cause of Death	Health Concerns
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (i.e. Cancer, heart disease, stroke etc.)				

Please check any of the following that pertain to your immediate family:

Allergies		Arthritis		Asthma		Autoimmune diseases	
Birth defects		Bleeding disorders		Cancer		Deafness	
Depression		Diabetes		Eczema		Heart disease	
Hepatitis		Herpes		HIV/AIDS		Hypertension	
Kidney disease		Mental illness		Peptic Ulcer		Thyroid disease	
Tuberculosis		Visual problems		Other			

If other, please explain: ____

PRENATAL HISTORY

Please check any conditions experienced by mom during pregnancy:

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
German Measles		Herpes		Hypertension		Infections	
Nausea		Physical trauma		Pregnancy Induced hypertension (PIH)		Thyroid Problems	
Vomiting		Weight gain/loss		Other			

If other, please explain: ____

Please indicate any emotional traumas that mom experienced during pregnancy: ____________________________
____

Please list any medications taken during the pregnancy (include over the counter): ____________________________
____
____

Did mom use any of the following during pregnancy?
Cigarettes: Y / N how often? _____________ Alcohol: Y / N how often? ______________
Caffeine: Y / N Drugs: Y / N If yes, please list: ____

Please list any supplements taken during pregnancy: ____
____
____

How would you describe the pregnancy? ____
____

Was there any history of a complicated pregnancy before the birth of this child? __________________________
____

BIRTH HISTORY

Length of gestation? 9months ______ Early ___days ___wks Late ___days ___wks
Length of labour? _________________________
Was labour spontaneous? Y / N If no, how was it induced? _____________________________________
Type of delivery? Vaginal ____ C-section ____ Emergency c-section _____
Location of delivery? Home ____ Hospital ____ Birthing center ____ other ________________________
Parties present for birth: ____
Any interventions used? Anesthesia ____ Epidural ____ Episiotomy ____ Forceps ____
Vacuum ____ Other ____
What was the child's weight at birth? ____________ length? ___________

Please check if any of the following were experience at or soon after your child's birth:

Allergic reactions		Birth defects		Colic		Difficulty feeding	
Fevers		Failure to thrive		Hypoxia		Jaundice	
Meningitis		Rashes		Respiratory difficulties		Seizures	
Unusual weight gain/loss		Other					

If other, please explain: ____

Did your child undergo any of the following interventions? Incubation ____ Medications ____
Respirator ____ Surgery ____ Billi-lights ____ Other _______________________________

CHILD'S HEALTH HISTORY

Does your child sleep through the night? Y / N # of hours _____
What is their napping pattern during the day? ____
Do they suffer from nightmares? Y / N
Does your child have any known allergies? If yes, please list: ______________________________________
____
Have they ever been hospitalized? (reason and dates):____
____

Please check any of the following that pertain to your child:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Walking/crawling problems		Whooping cough	
Other							

If other, please explain: ____

Has your child ever traveled outside this country? Y / N Where? ____________________________________

IMMUNIZATION HISTORY

Please indicate approximate dates where possible:
Measles, Mumps, Rubella (MMR): _______________ Polio: ____________ Small Pox: _____________
Influenza: ____________ Hepatitis: ___________ Chicken Pox: __________
Diphtheria, Pertussis, Tetanus (DPT): ____________ Other: ______________
Please check if any adverse or odd reactions?

Fever		Excessive crying		Pain		Swelling	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please explain: ____

NUTRITIONAL HISTORY

Was your child breastfed? If yes, for how long? _____________
If no, please indicate what food was used and include brand: ____
What was the first liquid introduced to your child after this (excluding water)? _____________________________

Please make a brief list of solid foods in the rough order of introduction:

FOOD	**AGE OF INTRODUCTION**
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Did you notice any adverse reaction to the above mentioned or any other foods?
____

Is your child a vegetarian? Y / N
How would you describe your child's eating habits? ____
____

Please give a rough outline of your child's daily diet:
Breakfast: ____
Lunch: ____
Supper: ____
Snacks: ____
Water intake: ____
Other fluids: ____
Nutritional Supplements: ____

SOCIAL HISTORY

How would you describe your child's temperament? ____
____
How does your child interact with other people? Adults? ____________________________________
Other children? ____
Have they experienced any emotional traumas? ____
____
How do they handle stress? ____
____
How does your child express their emotions? ____
____
How would you describe your child's performance at school? _____________________________________
____
How do you think other people would describe them? ____
____
Have you ever noticed any behavioral problems at school/daycare/sitters? ____________________________
____
Does your child take part in any extracurricular activities? ____________________________________
____

HOME ENVIRONMENT

How many people live in your home? _______________________
Are there any smokers in your home? Y / N
Do you have any pets? ___________________________________
How old is your home, approx.? ____________________________
How is your home heated? ________________________________
How would you describe the emotional climate in this child's household? (I know this is a tough question, please just give me your best idea) ____
____

Is there anything else you would like to tell me about your child? _________________________________
____
____
____
____
____
Any other comments? ____
____

Thank you for taking the time to fill in this lengthy questionnaire. It will be a valuable resource for us as well as a great time saver in your first appointment. Looking forward to seeing you in the near future.