

PEDIATRIC HEALTH QUESTIONNAIRE 6-12 YRS

I appreciate the length of this form; however, your cooperation in completing it to the best of your ability is essential to providing your child with the highest standard of care. When possible please encourage your child's input to increase the accuracy of this intake. All information you provide here will be kept absolutely confidential. This is a general pediatric form, depending on the age of your child this may not all apply; for those sections that do not apply please indicate with "NA". If you have any question please ask. PLEASE PRINT your responses clearly. Thank you.

PERSONAL INFORMATION

Patient Name: _____ Today's Date: _____
 Date of Birth: _____ (d/m/y) Age: _____ Gender: M F AB Health Care #: _____
 Home Address: _____ City: _____ Prov/ State: _____
 Postal Code: _____ Phone (home): _____ Phone (other): _____
 Ethnicity: _____ *(for genetic health risk assessment purposes only)*

Mother or Legal Guardian's Name: _____
 Address: (if different from above) _____

Phone (home): _____ Phone (work): _____ Phone (cell): _____
 Occupation: _____

Father or Legal Guardian's Name: _____
 Address: (if different from above) _____

Phone (home): _____ Phone (work): _____ Phone (cell): _____
 Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you wish to be contacted occasionally by email regarding clinic news: Yes No

List of Other Healthcare Providers:

Medical Doctor(s): _____ Phone: _____
 Naturopathic Physician: _____ Phone: _____
 Chiropractor: _____ Phone: _____
 Others: _____ Phone: _____

How did you hear about our clinic?

CURRENT HEALTH CONCERNS

What is the main reason that you are seeking naturopathic care for your child?

When did this issue begin? _____ Has it been improving worsening or remaining the same

Please list any treatments received for this condition (medication, surgery, massage etc.) and the results of these treatments. Please include dates. _____

Please list in order of importance, any other health concerns.

- 1) _____ Began when? _____
- 2) _____ Began when? _____
- 3) _____ Began when? _____
- 4) _____ Began when? _____

What is your level of commitment to addressing the underlying causes of your child's health concerns including any necessary lifestyle changes? (10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Please list your specific short and long term health goals you have for your child. _____

CURRENT HEALTH HISTORY

Please list any **allergies** to medications, foods, animals, other? _____

Please list all **medications** your child is currently taking, including dosage and results: _____

Please list all **supplements**, herbs, vitamins or homeopathic medicines your child is taking, including dosage and results: _____

What is your child's blood type? _____

Current Weight: _____

PAST MEDICAL HISTORY

Please circle any of the following childhood diseases your child has had:

Typhoid fever Whooping cough Mumps Chickenpox Diphtheria Polio Roseola
 Rheumatic fever Scarlet fever Measles Small pox Tuberculosis Rubella Mono

Please list any major traumas (including broken bones), surgeries and/or hospitalizations not previously mentioned above (include dates): _____

Please check all of the following vaccines your child has received and list the date it was received and list the date each was received:

- | | |
|---|--|
| <input type="checkbox"/> Diphtheria, Pertussis, Tetanus, Polio, | <input type="checkbox"/> Pneumococcal (Pneu C-7) |
| <input type="checkbox"/> Haemophilus Influenza B (DPT, PHib) | <input type="checkbox"/> Meningococcal (Men -C) |
| <input type="checkbox"/> Measles, Mumps, Rubella (MMR) | <input type="checkbox"/> Human Papilloma Virus (HPV) (Gardasil®) |
| <input type="checkbox"/> Influenza (flu shot) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hepatitis A and/or B (Hep A/B) | |

Has your child ever had an adverse reaction to a vaccine, if so, which one, please describe:

PRENATAL HISTORY

PARENT'S HEALTH

Mother's age at conception: _____

What was the mother's level of health just prior to and during her pregnancy? _____

Did the mother take any medications while pregnant? (name and dose) _____

Did the mother smoke, drink alcohol or take any illicit drugs while pregnant? (what was taken, and how often) _____

Father's age at conception: _____

What was the father's level of health just prior to conception? _____

NATAL HISTORY

Type of delivery (vaginal or C-section): _____

Where there any complications during the delivery? Explain: _____

Child's weight at birth: _____

Child's length at birth: _____

NEONATAL AND INFANCY HISTORY

Any issues with the child's health in first 3 months? _____

Was the child breastfed? Yes No For how long? _____

Was the child formula fed? Yes No For how long? _____

Age solid foods were introduced? ____ Did the child meet his/her developmental milestones? ____

FAMILY HISTORY

	Age	Health Problems	If deceased :	
			Age at death	Cause of Death
Father				
Mother				
Siblings				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Do any of your child's **relatives** currently suffer from or have they suffered from any of the following? Please indicate those which apply and list the relation.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genetic Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Schizophrenia | |

REVIEW OF SYMPTOMS

Please check all of the following symptoms your child is **currently experiencing** or experiences as a recurring issue.

GENERAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Cravings | <input type="checkbox"/> Sudden Drop in Energy (time?)_____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Bleed or Bruise Easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Strange Tastes or Smells |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Easy Weight Gain | |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Heat or Cold Intolerance | |

SLEEP

Does the child have difficulties sleeping? Describe: _____

- Difficulty Staying Asleep Snoring Bed Wetting
 Grind Teeth Sleep Apnea
 Nightmares, describe any recurring nightmares: _____

Does the child sleep with a light on? Yes No

How does your child prefer their covers? On Off

How does your child prefer the room when they are sleeping? Hot Cold Doesn't Care

Does your child sleep with a window open? Yes No

Please describe your child's preferred sleep position (back, abdomen, side): _____

How many hours does your child sleep in an average night? ____ Does he/she wake rested? ____

Average Bedtime: ____ Average Wake Time: ____ Is this consistent? ____

SKIN, HAIR AND NAILS

- Rashes or Hives Dandruff Bruise Easily
 Itching Changes in Hair or Skin Other Skin Nail or Hair Issue not listed?
 Eczema Texture
 Psoriasis Recent Moles
 Pimples Lumps
 Loss of Hair Ulcerations

HEAD, EYES, EARS, NOSE AND THROAT

- Headaches Color Blindness Jaw Pain or Clicking
 Neck Pain Blind Spots Tooth Pain
 Concussion(s) Earaches Gingivitis
 Eye Strain Poor Hearing Amalgam (silver colored metal) fillings
 Eye Pain Ringing in the Ears (Tinnitus)
 Blurred/ Double Vision Use of Hearing Aid Date of last dental exam: ____
 Tearing or Dryness Facial Pain Recurrent sore throats
 Use of Glasses Sinus Issues Sores on lips, tongue or inside of cheeks
 Date of last eye exam: ____ Nose Bleeds

HEART AND CIRCULATION

- High Blood Pressure Chest Pain Cold Hands and Feet
 Low Blood Pressure Dizziness Swelling of Hands
 Irregular Heartbeat Fainting Swelling of Feet
 Palpitations / Fluttering Blood Clots

BREATHING AND LUNGS

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other Issues not listed? |
| <input type="checkbox"/> Pain with a Deep Breath | <input type="checkbox"/> Phlegm (color and consistency?) | |
| <input type="checkbox"/> Cough (Blood?) | | |

DIGESTION AND ELIMINATION

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Issues swallowing | <input type="checkbox"/> Bloating | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Nausea | <input type="checkbox"/> Rectal Sores |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramping | <input type="checkbox"/> Gas | <input type="checkbox"/> Diarrhea or Loose Stools |
| | <input type="checkbox"/> Constipation | |

What is your child's favorite food? _____

Is there anything your child will not eat? _____

Are there any foods you avoid giving your child (which foods and the reason e.g. allergy, religious, ethical, other): _____

Please describe your child's average daily diet.

Morning

Midday

Evening

Please describe your child's preference for the following tastes:

- | | | | |
|--------|------------------------------------|---|---|
| Sweet | Loves It! <input type="checkbox"/> | Doesn't like it at all <input type="checkbox"/> | Will take it or leave it <input type="checkbox"/> |
| Salty | Loves It! <input type="checkbox"/> | Doesn't like it at all <input type="checkbox"/> | Will take it or leave it <input type="checkbox"/> |
| Sour | Loves It! <input type="checkbox"/> | Doesn't like it at all <input type="checkbox"/> | Will take it or leave it <input type="checkbox"/> |
| Bitter | Loves It! <input type="checkbox"/> | Doesn't like it at all <input type="checkbox"/> | Will take it or leave it <input type="checkbox"/> |

Is your child generally very thirsty? _____

Does your child sip or gulp drinks? _____

Does your child prefer hot or cold beverages? _____

How many bowel movements does your child have per day? _____

Are your child's stools formed? _____ Are they generally more loose or hard? _____

Can you see any of the following in your child's stool? Blood Mucous Undigested Food

What is the color of your child's stool? _____ Has it ever been black? Yes No

Do your child's stools generally float? _____ Are your child's stools generally greasy? _____

GENITO- URINARY

- | | | |
|--|---|---|
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Decreased Urine Flow | <input type="checkbox"/> Discharge from penis or vagina |
| <input type="checkbox"/> Urinary Urgency | <input type="checkbox"/> Distinctive Color | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Other Issues? _____ |
| <input type="checkbox"/> Inability to Hold Urine | | |

MUSCLES, JOINTS AND BONES

- | | | |
|---|---|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Other Joint or Bone Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Foot/ Ankle Pain | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Hand/ Wrist Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Shoulder Pain | | |

BRAIN, NERVES AND EMOTIONS

- | | | |
|---|---|--|
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Areas of Numbness/ Tingling/ Paralysis | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> History of Concussion | <input type="checkbox"/> Anxiety/ Nervousness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Quick Temper | <input type="checkbox"/> Susceptible to Stress |

Has your child ever been treated for any emotional issues? _____
 List any other neurological or psychological issues. _____

LIFESTYLE

SOCIAL HISTORY

Please describe any worries or fears your child has: _____

Please describe your child's relationships with friends: _____

Education level: _____ General Academic Performance: _____

Does your child enjoy school? _____

Do you know of any learning disabilities? _____

Please list extracurricular activities and hobbies: _____

Please list your child's involvement in sports: _____

Please describe any worries or fears your child has: _____

Please describe your child's relationships with friends: _____

HOME LIFE

What is the emotional environment of the child's home? _____

How many people live in the home? _____

Please list the names and ages of any siblings: _____

How is the child's home heated? _____ Is the home air conditioned? Yes No

Are there any pets/ animals in the home (please list number and kind): _____

Are there carpets in the home? Yes No In the child's bedroom? Yes No

Does anyone smoke in the home? Yes No

Do you suspect any exposure to lead in the home? (describe) _____

Do you suspect any exposure to mold in the home? (describe) _____

Please list any behaviors or habits you have noted (nail biting, thumb sucking, tics etc.): _____

Number of hours per day:

Watching TV: _____ Playing video games: _____ On the computer: _____

What is the child's favorite thing to do? _____

What is the child's least favorite thing to do? _____

TRAVEL

Please list all locations the child has traveled to (when, where and how long): _____

Please list all places you have lived (when, where and how long): _____

Has your child ever become sick while on vacation or shortly afterwards (describe): _____

PERSONALITY

Describe your child in five words or short phrases

1. _____
2. _____
3. _____
4. _____
5. _____

Thank you for taking the time to complete this form.

Please return your forms to the front desk or doctor



Naturally Inclined Health

Suite 300, 8225 105 St NW Edmonton AB T6E 4H2

Phone: 780 757 7700 Fax: 1 833 790 2923

Info@naturallyinclinedhealth.com www.naturallyinclinedhealth.com

CONSENT FORM

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST VISIT

Naturopathic medicine is a style of medicine which approaches individual health, condition treatment and disease prevention primarily by natural means. Naturopathic physicians consider the whole person taking into account physical, biochemical, mental and emotional aspects of each person and works to find the root cause of disease and to stimulate the innate healing ability of the body.

There is a slight potential of risk involved in naturopathic medical care. These risks include but are not limited to the following:

- Allergic reaction to supplements, herbs, topical products, IV or injectable components
- Aggravation of pre existing symptoms or condition(s)
- Mild pain, bruising or minor bleeding following acupuncture, injection therapies or venipuncture
- Very minor risk of stroke, disc herniation or fracture related to naturopathic skeletal manipulation

I _____(guardian) understand that my identity and the identity of my child will be protected at all times and that a health record will be kept detailing health services provided to my child. This record will be kept confidential and will only be released under my specific direction or as required by law. I also consent to the use of information in my child's medical record for research purposes and understand that my identity and that of my child will always be protected and kept absolutely confidential.

I commit to informing my Naturopathic Doctor immediately of any disease or conditions my child suffers from and will continue to update my Naturopathic Doctor with all pertinent changes in my child's health.

I understand that the Naturopathic Doctor will answer any of my questions to the best of her ability. I understand that results are not guaranteed. I do not expect the Naturopathic Doctor to anticipate and explain all risks and potential complications involved in naturopathic care. With this knowledge, I voluntarily consent to diagnostic and treatment procedures by my Naturopathic Doctor. I understand that my consent, as indicated on this form, will cover the entire duration of my child's clinical relationship with his/her naturopathic doctor, until which time they are legally eligible to provide their own consent. I also understand that I am free to withdraw this consent in writing and that I may discontinue participation in any procedure at any time.

Patient Name: (please print) _____

Name of Guardian: (please print) _____

Signature of Guardian: _____

Date: _____ Naturopathic Doctor: _____

Naturally Inclined Health
 Suite 300, 8225 105 St NW Edmonton AB T6E 4H2
 Phone: 780 757 7700 Fax: 1 833 790 2923
Info@naturallyinclinedhealth.com
www.naturallyinclinedhealth.com