PEDIATRIC HEALTH QUESTIONNAIRE 0-5YRS

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. 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 or you may not remember; 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? _____

Any other concerns?_____

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:

- ☐ Diphtheria, Pertussis, Tetanus, Polio, Haemophilus Influenza B (DPT, PHib)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Influenza (flu shot)
- ☐ Hepatitis A and/or B (Hep A/B)
- ☐ Pneumococcal (Pneu C-7)
- ☐ Meningococcal (Men –C)
- ☐ Human Papilloma Virus (HPV) (Gardasil®)
- ☐ Other

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

PRENATAL HISTORY

MOTHERS HEALTH

What was the child's mother's level of health just prior to and during her pregnancy?_____
_____
Mother's age at conception:_____ Duration of pregnancy (weeks):_____
Weight mother gained during 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)_____
Was the mother taking any supplements while pregnant? (name, brand and dose)_____
_____
_____

Please check any of the following symptoms experienced by the mother during the pregnancy:

- ☐ Heartburn Severity: _____ Length of Time: _____
- ☐ Nausea/ Vomiting Severity: _____ Length of Time: _____
- ☐ High Blood Pressure Maximum Reading: _____ When did BP rise in pregnancy? _____
- ☐ Diabetes Fasting Blood Sugar Reading: _____
- ☐ Trauma Describe, including date: _____
- ☐ Seizure Type: _____ Date: _____
- ☐ Other Describe: _____

Was the pregnancy considered high risk? Yes ☐ No ☐ Why? _____
What was the mothers general emotional state while pregnant?_____
Was the mother consuming a healthy balanced diet while pregnant? _____
How much and what type of exercise was the mother doing while pregnant? _____
_____

FATHER'S HEALTH

What was the father's level of health just prior to conception? _____
Father's age at conception: _____

NATAL HISTORY

Type of delivery (vaginal or C-section): _____
Where there any complications during the delivery? Explain: _____
_____
_____
Where any medications used during the delivery? _____
Where suction or forceps used during the delivery?_____
Childs 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? _____
If the child was formula fed list the type and brand: _____

FOOD INTRODUCTION

At what age was food first introduced? _____
What were the child's first foods? 1st_____ 2nd_____ 3rd_____ 4th _____
Were these foods well tolerated? Any reactions or concerns noted at this time? _____
_____
How was the child's health at one year of age? _____

DEVELOPMENTAL MILESTONES

Please list the age at which your child first did each of the following:

Held own head up: _____	Walked with help: _____	Said a full sentence: _____
Rolled over: _____	Walked on own: _____	Tied own shoes: _____
Crawled: _____	Said first word: _____	Got dressed on own: _____
Sat up with support: _____	Said several words	Fully toilet trained: _____
Sat up unsupported: _____	together: _____	Rode a tricycle: _____

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.

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Genetic Disease
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

REVIEW OF SYMPTOMS

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

GENERAL

- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Poor Appetite
- ☐ Change in Appetite
- ☐ Cravings
- ☐ Strong Thirst
- ☐ Weight Gain
- ☐ Heat or Cold Intolerance
- ☐ Weight Loss
- ☐ Sudden Drop in Energy (time?)_____
- ☐ Bleed of Bruise Easily

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? _____
If your child naps how often and how long does he/she nap? _____

SKIN, HAIR AND NAILS

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

HEAD, EYES, EARS, NOSE AND THROAT

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

HEART AND CIRCULATION

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

BREATHING AND LUNGS

- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Pain with a Deep Breath
- ☐ Cough (Blood?)
- ☐ Bronchitis
- ☐ Asthma
- ☐ Phlegm (color and consistency?)
- ☐ Pneumonia
- ☐ Other Issues not listed?

DIGESTION AND ELIMINATION

- ☐ Issues swallowing
- ☐ Bad Breath
- ☐ Heartburn
- ☐ Abdominal Pain or Cramping
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Constipation
- ☐ Rectal Pain
- ☐ Rectal Sores
- ☐ Hemorrhoids
- ☐ Diarrhea or Loose Stools

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 reason): _____

_____

Please describe your child's average daily diet.

Morning Midday Evening

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

Sweet	Loves It! ☐	Doesn't like it at all ☐	Will take it or leave it ☐
Salty	Loves It! ☐	Doesn't like it at all ☐	Will take it or leave it ☐
Sour	Loves It! ☐	Doesn't like it at all ☐	Will take it or leave it ☐
Vinegar	Loves It! ☐	Doesn't like it at all ☐	Will take it or leave it ☐

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

- ☐ Frequent Urination
- ☐ Urinary Urgency
- ☐ Pain on Urination
- ☐ Inability to Hold Urine
- ☐ Decreased Urine Flow
- ☐ Distinctive Color
- ☐ Blood in Urine
- ☐ Discharge from penis or vagina
- ☐ Sores on Genitals
- ☐ Other Issues?_____

MUSCLES, JOINTS AND BONES

- ☐ Neck Pain
- ☐ Back Pain
- ☐ Hand/ Wrist Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Foot/ Ankle Pain
- ☐ Hip Pain
- ☐ Other Joint or Bone Problems?
- ☐ Muscle Pain
- ☐ Muscle Weakness

BRAIN, NERVES AND EMOTIONS

- ☐ Loss of Balance
- ☐ Lack of Coordination
- ☐ Dizziness
- ☐ Seizures
- ☐ Areas of Numbness/Tingling/ Paralysis
- ☐ History of Concussion
- ☐ Poor Memory
- ☐ Quick Temper
- ☐ Irritability
- ☐ Anxiety/ Nervousness
- ☐ Depression
- ☐ 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: _____
_____

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

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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: _____

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