|  |  |  |
| --- | --- | --- |
|  | Date of first Appointment: | Click here to enter a date. |
| HEALTH QUESTIONNAIRE Child – PAGE 1*All questions contained in this questionnaire are strictly confidential* |
| Name of child(**last, first):** Click here to enter text. | **Sex:** choose | **Date of birth :** click |
| Place of birth: Click here to enter text. | **Blood type:** click. | **Age:** click. |
| Current Height: Click here to enter text. | **Current Weight:**  click. | **Class in school**: Click. |
| **Date of last medical exam**:click. | **Sex & age of siblings:** click. click**.** |
| Whom does the child live with? Click here to enter text. | Any pets living at home: Click here to enter text. |
| Name of Parent/Guardian: Click here to enter text. | Cellular phone: Click here to enter number. |
| Occupation: Click here to enter text. | Office phone : Click here to enter number. |
| Adresse home*: (number, street)* Click here to enter text. | Town: Click here to enter text. |
| Province, Country : Click here to enter text. | Postal Code: Click here to enter text. |
| **E-mail:** Click here to enter text. | **Home phone:** Click here to enter number. |
| Emergency contact: *(name/relation)* Click here to enter. | Emergency phone: Click here to enter number. |
| Name of pediatrician/doctor: Click here to enter text. | **Doctor’s phone:** Click here to enter number. |
| Other health care professionals: Click here to enter text. |
| Does your child have mercury fillings in their teeth? | . |
| **Has your child or your family experienced a major tragic change or loss?***(death, divorce, accident, etc.)* | . |
| If yes, date and details: Click here to enter text. |
|  |
| **DOES YOUR CHILD SUFFER FROM ANY ALLERGIES?** *(medicines, foods, environmental. Complete the table below)* |
| **Name of allergen:** *medicine, food, other…* | **Since** | **Reaction that occurred/symptoms** |
| 1. Click here to enter text.
 | . | Click here to enter text. |
| 1. Click here to enter text.
 | . | Click here to enter text. |
| 1. Click here to enter text.
 | . | Click here to enter text. |
| 1. Click here to enter text.
 | . | Click here to enter text. |
|  |
| **CHIEF HEALTH CONCERNS YOU WISH TO ADDRESS BY ORDER OF PRIORITY:***onset date, severity, previous treatments, outcome* |
|  | Condition | **Since** *(yr/mth)* | **Treatments and results** *(none, mild, moderate, excellent)* |
| **1.** | . | . | Click here to enter text. |
| **2.** | . | . | Click here to enter text. |
| **3.** | . | . | Click here to enter text. |
| **4.** | **.** | . | Click here to enter text. |
| **5.** | **.** | . | Click here to enter text. |
|  |
| **IMMUNIZATIONS:** *Mark with an ‘X’ all the vaccines that your child has taken* |
| . | **Diphteria, pertussis, tetanus (DPT)** | . | **Influenza**  | . | **Pneumonia** |
| . | **Measles, Mumps, Rubella (MMR)** | . | **Chicken pox** | . | **Meningococcal** |
| . | **Polio** | . | **Hepatitis A** | . | **Herpes Zoster** |
| . | **Small pox** | . | **Hepatitis B** | .  | **Other** |
| HEALTH QUESTIONNAIRE Child – PAGE 2*All questions contained in this questionnaire are strictly confidential* |
| **CHILDHOOD ILLNESSES** | **Yes/No** | **Date** | **Severity (acute or chronic/ yearly frequency) treatments and results, …**  |
| **Allergies**  | . | . | Click here to enter text. |
| **Chicken pox** | . | . | Click here to enter text. |
| **Chronic ear infections** | . | . | Click here to enter text. |
| **Frequent colds** | . | . | Click here to enter text. |
| **Measles** | . | . | Click here to enter text. |
| **Mumps** | . | . | Click here to enter text. |
| **Pneumonia** | . | . | Click here to enter text. |
| **Rheumatic fever** | . | . | Click here to enter text. |
| **Rubella** | . | . | Click here to enter text. |
| **Scarlet fever** | . | . | Click here to enter text. |
| **Strep throat** | . | . | Click here to enter text. |
| **Tonsillitis** | . | . | Click here to enter text. |
| **Polio** | . | . | Click here to enter text. |
| **Other** | . | . | Click here to enter text. |
| **DATES AND LIST OF ALL SURGERIES, HOSPITALIZATIONS OR INJURIES SUFFERED IN THE PAST**  |
| Date. | Click here to enter text. |
| Date. | Click here to enter text. |
| Date. | Click here to enter text. |
| Date. | Click here to enter text. |
| Date. | Click here to enter text. |
| Date. | Click here to enter text. |
| HAS YOUR CHILD RECEIVED A BLOOD TRANSFUSION IN THE PAST? | . |

|  |
| --- |
| **LIST ALL PRESCRIPTION MEDICATIONS, SUPPLEMENTS, INHALERS CURRENTLY BEING TAKEN** |
| **Name of medicine or supplement***(composition & brand name)* | **Strength & Frequency***(ex. mg/pill & number of pills/day)* | **Reason**  | **Outcome** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | . |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | . |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | . |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | . |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | . |
| **FAMILY ANTECEDANTS** *(cancer, diabetes, cardiovascular disease, high blood pressure, remal disease , Alzheimer, arthritis, osteoporosis, …)* |
|  | **Age** |  **Serious health problems or age deceased**  | **Brothers/Sister** | **Age** | **Serious health problems or age deceased** |
| **Mother** | . | Click here to enter text. | . | . | Click here to enter text. |
| **Father** | . | Click here to enter text. | . | . | Click here to enter text. |
| **Maternal Grandmother** | . | Click here to enter text. | . | . | Click here to enter text. |
| **Maternal Grandfather** | . | Click here to enter text. | . | . | Click here to enter text. |
| **Paternal Grandmother** | . | Click here to enter text. | Choose a relative. | . | Click here to enter text. |
| **Paternal Grandfather** | . | Click here to enter text. | Choose a relative. | . | Click here to enter text. |
| Choose a relative | . | Click here to enter text. | Choose a relative. | . | Click here to enter text. |
| Choose a relative | . | Click here to enter text. | Choose a relative. | . | Click here to enter text. |
| **HEALTH QUESTIONNAIRE Child – PAGE 3***All questions contained in this questionnaire are strictly confidential* |
| CURRENT & PAST SYMPTOMS *(choose: severe, moderate, mild, none or past)* |
| . | Diaper rash | . | Easy bleeding | . | Cries easily |
| . | Eczema | . | Nose bleeds | . | Sleep problems |
| . | Diarrhea | . | Frequent vomiting | . | Night sweats |
| . | Constipation | . | Stomach aches | . | Hair loss |
| . | Cradle cap | . | Fatigue | . | Dizzy spells |
| . | Dental caries | . | Burning of urine | . | Hearing loss |
| . | Unusual fears | . | Frequent urination | . | Cough |
| . | Perspiration, excessive | . | Bedwetting | . | Appetite change |
| . | Thirst, excessive | . | Blood in urine | . | Motion sickness |
| . | Discharges | . | Sore throats | . | Body/breath odor |
| . | Growing pains | . | Wheezing | . | Nervousness |
|  |
| MOTHER’S PRENATAL HISTORY *(Difficulties and/or toxicities encountered during her pregnancy)* |
| . | Emotional trauma | . | Nausea/vomiting | . | Diabetes |
| . | Physical trauma | . | High blood pressure | . | Thyroid conditions |
| . | Cigarettes | . | Herpes Simplex (HVS) | . | Supplement(s) |
| . | Alcohol | . | Toxemia | . | Medication |
| . | Recreational drugs | . | Bleeding | . | Diseases and other illnesses |
| Mother’s place of birth : | Click here to enter text. |
| Did you travel during your pregnancy? Where? | Click here to enter text. |
| Did you work during your pregnancy? | Click here to enter text. |
| Marital status and stability of the home | Click here to enter text. |
| Parents’ age at time of conception |  Father : . Mother: . |
| Parents’ health at time of conception |  Father : . Mother : .  |
| Father: any exposure to smoking, alcohol, drugs, toxins, etc.  | Click here to enter text. |
| **BIRTH HISTORY** |
| Premature, full, late delivery | Click here to enter text. |
| Weight/height at birth | Click here to enter text. |
| Home or hospital birth | Click here to enter text. |
| Lenth of Labor:  | Click here to enter text. |
| **Interventions used:** *Pain medS, epidural, forceps, vacuum, pitocin, … :* Click here to enter text. |
| Mother’s emotional state post-partum *(post-partum depression, etc..)* | Click here to enter text. |
| Any post-partum incidents : *(breast-feeding, respiratory distress, etc.)* | Click here to enter text. |
| HEALTH QUESTIONNAIRE Child – PAGE 4*All questions contained in this questionnaire are strictly confidential* |
| **Neonatal History** |
| . |  | Birth defects | . | Anemia |
| . |  | Birth injuries | . | Infection(s) |
| . |  | Jaundice | . | Rashes  |
| . |  | Respiratory distress | . | Colic |
| . |  | Weight gain, poor breast-feeding, eats little | . | Seizures |
| FEDING HISTORY |
| Breast-fed, how long, any problems? | Click here to enter text. |
| Baby formula: which one, at what age? | Click here to enter text. |
| At what age was solid food introduced:  | Click here to enter text. |
| What food was first introduced? | Click here to enter text. |
| At what age was cow’s mild introduced? | Click here to enter text. |
| List any food exclusions from child’s diet? | Click here to enter text. |
| Is your child currently a picky eater?  | Click here to enter text. |
| **SLEEP HABITS** |
| During first year of life | Click here to enter text. |
| At present | Click here to enter text. |
| Any napping? Time(s) | Click here to enter text. |
| Any trouble falling asleep or staying awake? | Click here to enter text. |
| Any bedwetting, till what age? | Click here to enter text. |
| Bedtime and waking time | Click here to enter text. |
| **Behavior and emotional history** |
| At school: performance, anxiety, separation anxiety | Click here to enter text. |
| At home | Click here to enter text. |
| Relationship with friends, family, siblings  | Click here to enter text. |
| Potty training, at what age? | Click here to enter text. |
| Interests and/or activities they partake in | Click here to enter text. |
| How often does your child exercise per week? | Click here to enter text. |
| Fears | Click here to enter text. |
| Any travel outside Canada? Where? | Click here to enter text. |
| At what age was your child first: Sitting alone : . , Walking: . ,Talking . , Rolling over: . , First tooth: . |
| Any additional comments or information that you would like to share: Click here to enter text. |
| Click here to enter text. |
| Click here to enter text. |
| . |
| HEALTH QUESTIONNAIRE Child – PAGE 5*All questions contained in this questionnaire are strictly confidential* |
| **DIET JOURNAL** |
| * Fill out this form on 5 consecutive days and send it back with the questionnaire or print it & bring it with you to the first appointment
* Write down everything that enters their mouth, including water, snacks, soft drinks, etc.
* List all contents and ingredients found inside mixed dishes and prepared foods (ex. kind of flour, spread, condiments, spices, etc.)
* Be sure to give as much information and detail as possible in each entry that you make
 |
| **Date** | **Breakfast** | **Lunch** | **Dinner** | **Snacks & beverages** | **Digestive, urinary, skin complaints** | **Overall energy & mood** |
| **Day 1**. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Day 2**. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Day 3**. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Day 4**. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Day 5**. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

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| **IMPORTANT INFORMATION & DISCLAIMER** |
| *Please read the following terms and conditions and check the ‘’I agree’’ box at the bottom with an ‘’X’’ to indicate that you agree* |
| The information and advice provided may not be construed as medical advice nor is it intended to diagnose, treat, suggest a course of treatment, cure or prevent any disease or condition. It is neither intended nor implied to be a substitute for professional medical advice.  |
| Any users should always seek the advice of their physician prior to beginning any treatment and never disregard professional medical advice  |
| Or delay in seeking such advice because of information obtained from us. |
| **DISCLAIMER** |
| I also acknowledge that I, |  .  | am the legal guardian of |  .  |
| And that I am personally responsible for all the information given to the naturopath regarding the health of my child. I also acknowledge that I understand that all advice, food plans and suggested natural supplements are tools to improve the physiology and/or body biochemistry. They are not intended to heal any type of disease and no diagnosis will be established. |
| I certify that I am over 18 years of age and that I have read, understood and agreed to the terms and conditions above | I Agree . |