|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | 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. | | | | | | | | | |
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| **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? | | | | | | | | | | | | | | | | . |

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| **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 . |