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NATUROPATHIC CLINIC

PEDIATRIC HEALTH HISTORY

New patient visits are 1 hour in length. It may be difficult for your child to sit through an appointment for this amount of time, so please feel free to bring toys or movies that will make them feel more comfortable during their appointment. This will ensure that we can maximize our ability to collect the necessary information regarding your child's health, so that we may best help them in their health journey.

Alternatively, if you have sensitive issues that you would like to discuss regarding your child's health, please feel free to bring another adult to the appointment that can accompany your child outside for some playtime. For safety reasons, we cannot allow unsupervised children in the waiting room.

Date: _____

Child's First Name: _____ Last Name: _____

Age: _____ Birth date: _____ / _____ Gender: _____

Who is filling out this form? (name) _____

Contact Information:

Name _____ Phone: (h): (_____) _____

Address: _____

_____

(w): (_____) _____ (other) _____

Relationship to child: _____

With whom does the child live? :

_____

Other Healthcare providers this child is seeing: (please give name, type of practitioner /specialist, and contact information if you can)

1.	2.	3.

Primary Problem:

_____

(this will be discussed in detail in your first visit)

Other health concerns, in order of importance to you:

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

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Medical History

How would you describe your child's general state of health?

☐ excellent ☐ good ☐ fair ☐ poor

Please indicate any serious conditions, illnesses, injuries or hospitalizations, along with dates:

Which of the following illnesses has your child had? Check all that apply

☐ rubella (German measles)
☐ scarlet fever
☐ whooping cough
☐ skin concerns (eg. Rashes)
☐ roseola
☐ chicken pox
☐ strep throat
☐ impetigo
☐ mononucleosis
☐ tonsillitis
☐ measles
☐ ear infections
☐ mumps

if yes, please note if there were any complications to these illnesses:

Vaccination/Immunization Record: Check all that apply

☐ DTAP (diphtheria, pertussis, tetanus)
☐ BCG (Tuberculosis)
☐ Pneumococcal Conjugate (meningitis/pneumonia)
☐ MMR (measles, mumps, rubella)
☐ Hepatitis A
☐ Gardasil/Cervarix (HPV)
☐ Menigococcal C (meningitis)
☐ Hepatitis B
☐ Varivax/Varilix (chicken pox)
☐ Polio
☐ Haemophilus Influenza B
☐ Flu vaccine
☐ Other : _____

Did any of the vaccines cause an adverse reaction? (fever, rash, temperament changes etc.)

Does your child have any allergies (medicines, environmental, foods)?

Please list any current medications (prescription and over the counter) and reason for taking:

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Please list any previously diagnosed medical conditions and their treatments:

1. _____
2. _____
3. _____

Family History

Please indicate if there are any issues concerning heart health, high blood pressure, cancer, mental illnesses, thyroid problems, kidney disease, gastrointestinal diseases, arthritis, auto-immune conditions and any other relevant health information

	Age	Health History			Age	Health History	
Father				Mother			
Grandmother (Paternal)				Grandmother (Maternal)			
Grandfather (Paternal)				Grandfather (Paternal)			
Siblings (eldest to youngest) 1		Gender		Sibling 3		Gender	
Sibling 2		Gender		Sibling 4		Gender	

Prenatal History

Prenatal Influences: ☐ Alcohol ☐ coffee ☐ cigarettes ☐ drugs ☐ stress ☐ other _____

Mother's age at conception: _____ Father's Age at conception: _____

Were fertility interventions used? _____

Pregnancy health: did the mother experience any of the following:

☐ Nausea ☐ High blood pressure ☐ Diabetes ☐ Emotional Trauma
☐ Vomiting ☐ Physical Trauma ☐ Major illnesses ☐ Excessive Bleeding
☐ Other: _____

What was the mother's emotional health like during pregnancy:

List all medications/supplements taken during pregnancy and labour:

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Labour/ Birth History

What type of delivery: ☐ Vaginal birth ☐ C-Section ☐ Hospital ☐ Home Birth

Term length: _____ weeks Duration of Labour: _____

Was labour induced?: ☐ Y ☐ N

Were there difficulties during the labour?:

Interventions during Labour:

☐ Antibiotics ☐ Epidural ☐ Episiotomy ☐ Forceps ☐ Suction ☐ Fentanyl

APGAR Score: 1 min: ____ 5 min: ____ Birth Weight: _____ Length: _____

Did the child experience any of the following:

☐ Jaundice ☐ Birth Injuries ☐ Rash ☐ Infection
☐ Colic ☐ Feeding Difficulties ☐ Seizures ☐ Respiratory Distress
☐ Congenital Conditions: _____
☐ Other complications/illnesses: _____

Interventions used after birth: ☐ Vitamin K ☐ Silver Nitrate Drops
☐ Other _____

Diet / Lifestyle

Nutrition/Feeding:

Was the child breastfed?: ☐ Y ☐ N If yes, For how long? _____
Was the child formula fed: ☐ Y ☐ N If yes, when was it started? _____
Age at 1st solid food: _____ Any reactions: _____
What were the 1st foods? _____
Is the child: ☐ Vegan ☐ Vegetarian
☐ Other _____
Is your child a good eater? _____
Has the child reacted to any foods? (rash, vomiting, etc...)

Development and Social History

At what age did the child

Roll over: _____ Sit up: _____ Crawl: _____ Walk: _____

Teeth: _____ Talk: _____ Toilet train: _____

How does the child interact with friends/family?

Is there anything that the child finds particularly stressful?

Does the child exercise regularly? ☐ Y ☐ N Hours/day: _____

Type of exercise:

Number of hours per day for: TV _____ Video Games _____ Computer _____

Is there any other important information or concerns that you would like to address in our visits?

Thank you for taking the time to fill out the health history form. Please print and bring with you to your first appointment.

Alternatively, you can click "submit" and email it directly to Whole Medicine Wellness Centre

PRINT