NATUROPATHIC HEALTH HISTORY – Infant/Child

Child's full name_____ Date of Birth _____ Age___
Gender _____ MSP # _____
Place of birth (city/country) _____

Child's current address _____

How did you hear about me? _____
Who is filling out this form (name and relation)? _____

MOTHER/GUARDIAN _____

Address (if different from child's) _____

Phone (H) _____ (W) _____ (cell/pager) _____

e-mail _____

Occupation/Place of Work _____

FATHER/GUARDIAN_____

Address (if different from child's) _____

Phone (H) _____ (W) _____ (cell/pager) _____

e-mail _____

Occupation/Place of Work _____

Whom does the child live with? _____ Siblings? _____

EMERGENCY CONTACTS

Name _____ Phone (H) _____ (W) _____

Address _____ Relationship to child _____

Name _____ Phone (H) _____ (W) _____

Address _____ Relationship to child _____

OTHER HEALTH CARE PROVIDERS:

1._____ 2. _____ 3. _____

_____ _____ _____

Ph: _____ Ph: _____ Ph: _____

Please list your child's health concerns, in order of importance:

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

PRENATAL HISTORY

Mother's health at time of conception: Excellent Good Fair Poor Unknown

Father's health at time of conception: Excellent Good Fair Poor Unknown

Mother's health during the pregnancy: _____

Mother's diet during the pregnancy: (fair, excellent, etc.) _____

Mother's age at child's birth: _____

Did the mother receive prenatal medical care? _____ Midwifery care? _____ Other? _____

Are mother & child receiving postnatal care? _____ With whom? _____

Did the mother use any of the following during the pregnancy? How often?

Tobacco _____ Alcohol _____ Recreational drugs _____

Prescription medications _____

Over-the-counter medications _____

Supplements _____

Other _____

Did the mother experience any of the following during the pregnancy?

___ Bleeding ___ High blood pressure ___ Nausea ___ Vomiting

___ Diabetes ___ Thyroid problems ___ Physical/Emotional trauma

___ Other _____

FAMILY MEDICAL HISTORY (circle if yes**)**

Alcoholism	Heart disease	Cancer	Diabetes	Arthritis
Asthma	Eczema	Hay fever	Depression	Anxiety
Blood disorders	Seizures	High blood pressure	High cholesterol	
HIV	Other _____			

BIRTH HISTORY

Hospital birth? _____ Home birth? _____ Other? _____

Term length: ___ Full-term ___ Premature ___ weeks? ___Late ____ weeks?

Length of labour: _____ Child's weight at birth: _____

Any complications? _____

Was the birth: vaginal c-section induced forceps-assisted

Did the mother have an epidural, or make use of any other drugs during the birth? _____

Did the child experience any of the following at, or shortly after, birth?

___ Jaundice ___ Rashes ___ Seizures ___ Difficulty breathing

___ Birth injuries _____ ___ Birth defects _____

___ Use of medications (i.e. antibiotic drops in eyes) _____

APGAR SCORES (If known) _____

MEDICAL HISTORY

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

Weight _____ Length/Height _____ Rapid weight gain/loss? _____

Which of the following has your child had, and please indicate if any of these are recent:

Rubella (German measles)	Measles	Chicken pox	Mumps
Roseola	Scarlet fever	Strep throat	Whooping cough
Mononucleosis	Impetigo	Eczema	Ear infections
Pneumonia	Asthma	Cradle cap	Nightmares
Night sweats	Tonsillitis	Rashes	Diarrhea/Constipation
Lice	Pink eye	Bladder infection	Weight loss
Other _____			

Please indicate any serious illnesses/conditions (not listed above), injuries, or hospitalizations (including approximate dates):

_____

_____

Is your child immunized? _____

If yes, what were the most recent immunizations? _____

Please indicate if your child has ever experienced adverse reactions to any immunizations (such as rashes, low grade or high fever, seizures, extreme irritability, etc.)

_____

Does your child have any allergies that you know of?

Foods: _____

Animals: _____

Medications: _____

Environmental: _____

Please list all <u>current</u> medications (prescription, over-the-counter, vitamins, homeopathics, etc.):

_____

Please list all <u>past</u> medications, and results/side-effects if any noticed:

_____

How many times has your child been treated with antibiotics? _____

DIETARY HISTORY

Is/was your child breast-fed? _____ How long? _____ Any complications? _____
Has formula been used to either replace or supplement breastfeeding? _____
Cow's milk/Soy/Other _____ Any adverse reactions noticed? _____

Have foods been introduced into child's diet? _____ Beginning at what age? _____
Please list foods that were introduced before 6 months:

_____

Any adverse reactions to these? _____

Please list foods that were introduced at 6-12 months:

_____

_____

Any adverse reactions to these? _____

If the mother is breastfeeding, are there any foods in the mother's diet that are noticeably causing adverse reactions in child? _____

If eating solid foods:
Child's favourite foods: _____
Foods disliked: _____

Have you ever noticed any questionable reactions to food that have not been diagnosed as allergies?

_____

Do you have any dietary restrictions for your child (religious, vegetarian, etc.)?

_____

Please describe a typical day's diet:
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Any night-time snacking? _____

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Excellent Good Fair Poor Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep patterns:

_____

Does your child have any disabilities/impairments? (vision, hearing, speech, mobility, etc.)

_____

ENVIRONMENT

Is your child in: ___ Daycare ___ at home ___ School ___Other

How would you describe your child's general temperament, behaviour, and personality:

_____

_____

Are there any differences in these when they're not at home? _____

Child's favourite activities/hobbies: _____

Does your child get regular physical activity? (age appropriate of course) _____

Please describe _____

How much television does your child watch? ____ hours per day or week

How much does your child like to read (not for school) or be read to? _____

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N If yes, what? _____

How is the home heated? _____

Do you know of any toxins or other hazards that the child is regularly exposed to (at home, school, friends' homes, swimming pool, etc). _____

How would you describe the emotional climate of the child's home? Are there any significant stressors in your child's life?

_____

Is there anything that you feel is important that has not been covered by these questions?

_____

AND FINALLY……

Please describe, in the space below, your goals for your child's health:

Thank you for taking the time to fully complete this form.

Your diligence is appreciated and important to the process of taking care of your child's health.

If you have any questions about any item on this form, please contact me at the number or e-mail address below.

All information on this form is confidential and will not be shared with any individual or group unless explicit written consent is given by the child's legal guardian(s), or in the event of a life-threatening emergency.

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