

**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 current medications (prescription, over-the-counter, vitamins, homeopathics, etc.):

\_\_\_\_\_

Please list all past 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:

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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.

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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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Dr. Jane Reside, N.D.

723 Humboldt Street, Victoria, B.C. V8W 1B1

250-384-8038

[jane@drjane.ca](mailto:jane@drjane.ca)