

Child's Profile for Naturopathic Visit

Child's Name: _____ Age: _____ Date of birth: _____ Sex: _____
(m / d / y)

Address: _____ City: _____ Postal code: _____

Parent/Guardian contacts:

Mother's Name _____ Phone: (H) _____ (W/Cell) _____

Father's Name _____ Phone: (H) _____ (W/Cell) _____

Who referred you to us? _____ Alberta Health Care No. _____
(for file tracking purposes)

Family doctor _____ Chiropractor _____

Other practitioners in your child's health care team: _____

Email address (for policy, course info and health info updates) _____

A note to clients seeking naturopathic care for their children: Holistic, naturopathic and preventative health care are only possible when the doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Consider copying it for your own future records.

PRIMARY HEALTH CONCERNS:

In your opinion, what are your child's most important health concerns (chief complaints)?

Condition/complaint

Diagnosed By:

Since:

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

Which of the above problems are of most immediate concern to you as parents? _____

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated these health problems in your child? If you prefer, feel free to list these in chronological flow chart form on a separate page.

PRIOR TREATMENTS AND RESPONSE:

Please list all of the former treatments used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits your child received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan.

PRIOR DOCTOR-PATIENT RELATIONSHIPS

Please take a moment to reflect on your past relationships with your child’s care providers and note how the relationships with future care providers could improve to optimize health care for your child. What do you need from your doctor that you have not received? How can you become more effective in supporting your child’s health?

MEDICAL HISTORY

What childhood illnesses has your child had?

- Rubella (german/3 day measles) Measles (2 week) Mumps Chickenpox
- Whooping cough Polio Rheumatic fever Scarlet fever
- Roseola Asthma Mononucleosis _____

| | NOW | PAST | NEVER | | NOW | PAST | NEVER |
|--------------------|-----------------------|-----------------------|-----------------------|-------------------|-----------------------|-----------------------|-----------------------|
| Anemia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Arthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hypoglycemia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Asthma | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Allergies | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bleeding | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cradle cap | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cancer | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Eczema | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colic | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ear infections | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Heart murmur | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tonsillitis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mononucleosis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Headache | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Injury (serious) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pneumonia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Kidney disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Croup | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Liver dz./jaundice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hypothyroid | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Overweight | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hyperthyroid | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Ulcers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Strep throat | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Acne | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hyperactivity | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bed wetting | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Learning disorder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Vomiting spells | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Impetigo | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Please list all diseases, surgeries, accidents or traumatic events your child has experienced:

Disease, Surgery, Accident, Trauma Age Duration Recovery Treatment including meds

SURGERIES: Tonsils, Adenoids, Ear tube insertion, Heart, Appendix, Hydrocele, Birth defect

ACCIDENTS: Any major accident or injury to the body or head, any occasion of unconsciousness, any hemorrhage or major bleeding from any part of the body.

TRAUMA: Any serious shock, grief, major disappointments, severe fright, nervous breakdown, period of stress overload.

MEDICATIONS - List your child's present medications including drugs, vitamins, minerals, homeopathics, herbs:

| | | |
|----------------|----------|-------|
| Drug/Nutrient: | Purpose: | Dose: |
| Taken since: | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

Is your child allergic to any medicines or other substance? If yes, please list:

What happens when your child has an allergy attack? _____

What prior types of allergy testing has your child had?

- Intradermal
 Scratch
 Blood IgG food
 Blood IgE inhalant/food
 Cytotoxic
 Electroacupuncture (VEGA, MORA)
 Kinesiology
 Food intolerance testing
 None

FAMILY HISTORY -

Are this child's parents: Married _____ Common-law _____ Separated _____ Divorced _____

Are there any brothers or sisters to this child?

| Name | Age | State of health/health concerns |
|-------|-------|---------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list ages and if deceased, what they died from and at what age.

Maternal Side

Mother of child _____
 Aunts/uncles _____
 Grandfather _____
 Grandmother _____

Paternal side

Father of child _____
 Aunts/uncles _____
 Grandfather _____
 Grandmother _____

Has any BLOOD RELATIVE had any of the following:

| | YES | NO | UNSURE | | YES | NO | UNSURE |
|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|-----------------------|
| Anemia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hay fever or allergies | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Arthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Heart attack or disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Asthma | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High blood pr. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Birth defects | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Mental illness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bleeding | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Seizure/epilepsy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cancer | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Sickle cell anemia | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diabetes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Stroke | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Eczema | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Thyroid (hyper/hypo) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Glaucoma | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tuberculosis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gout | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Venereal dz. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other (specify) _____ | | | | - specify _____ | | | |

PRENATAL HISTORY

Describe mother's health during pregnancy with this child/infant/adolescent:

Mother's age when pregnant/delivery _____

| | YES | NO | UNSURE | | YES | NO | UNSURE |
|-------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Bleeding | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Emotional stress | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Nausea | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Xrays | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Toxemia of pregnancy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High blood pr. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Trauma/injury pre birth | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Drugs/smoking/alcohol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

TERM: Full ___ Premature(how many days/weeks?)_____ Late (how many days/weeks?)_____

Was pregnancy easy?___ difficult?_____

Was birth easy? ___ difficult?_____ Apgars _____

Place of birth: Hospital ___ Home ___ Clinic ___ Other _____

FEEDING/DIET HISTORY

Breastfed? ___ How long? _____ Was it easy/difficult? _____

Approximate feeding schedule _____

Formula? ___ How long?_____ Combined with breastmilk? _____

Types of formula used and response to each type if adverse:

Age solid foods began _____ What foods? _____

Adverse reactions to introduced foods: _____

How may meals does your child generally eat each day? One ___ Two ___ Three ___ More than three ___

Where do you usually buy your food? _____

How much of your child's food is prepared by you? _____

List the primary foods included in your child's diet: _____

List the foods you exclude from your child's diet: _____

List any of the following (and relative amounts) eaten regularly by your child. Pop, caffeinated teas, highly seasoned foods, processed foods, refined foods and any food you suspect might be harmful to his/her health.

List any foods your child seems to crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): _____

List all the foods the child refuses to eat: _____

Is your child thirsty? Yes No Amount of liquid child drinks each day _____ Amt. plain water _____

What temperature liquid does the child prefer to drink? ___ Hot ___ Cold ___Room temp.

Are you satisfied with your child's diet the way it is now? Why or why not? _____

VACCINATION HISTORY

Check off any that your child has received:

| | X | When? | Boosters | X | When? | Describe any adverse reactions |
|------------|-----|-------|--------------------|-----|-------|--------------------------------|
| DPT | ___ | _____ | | ___ | _____ | _____ |
| Diphtheria | ___ | _____ | | ___ | _____ | _____ |
| Pertussis | ___ | _____ | | ___ | _____ | _____ |
| Tetanus | ___ | _____ | Tetanus booster? | ___ | _____ | _____ |
| Measles | ___ | _____ | | ___ | _____ | _____ |
| Mumps | ___ | _____ | | ___ | _____ | _____ |
| Rubella | ___ | _____ | | ___ | _____ | _____ |
| Polio | ___ | _____ | Within past 2 yrs? | ___ | _____ | _____ |
| Hepatitis | ___ | _____ | | ___ | _____ | _____ |
| Hib | ___ | _____ | | ___ | _____ | _____ |
| Influenza | ___ | _____ | The last flu shot? | ___ | _____ | _____ |
| Meningoc. | ___ | _____ | | ___ | _____ | _____ |
| Chickenpox | ___ | _____ | | ___ | _____ | _____ |

Has your child been out of the country in the last 2 years? When? _____ Where? _____

Have you ever used homeopathics preventatively for infectious disease? _____

DENTAL HISTORY

Has your child been to see the dentist? Yes No

Describe any dental work done: _____

How many metallic fillings are present? _____ Have any been removed? _____

What is the oral hygiene practice of the child? _____

Is your toothpaste fluoridated? Yes No

VISION HISTORY

Has the child's eyes been checked? Yes No

Describe any vision problems: _____

BOWEL/URINARY HABITS

Frequency of stool _____ times per day, _____ times per week

Does your child have pain passing stool? _____

Have you ever been concerned about a bowel habit that your child has displayed? _____

Any urinary symptoms that you are concerned about? _____

SLEEP - Does your child have trouble falling asleep? Yes No

What is the pattern of sleep? _____

Does your child sleep straight through the night? Yes No

Does your child wake looking/acting refreshed? Yes No

Does your child have recurring dreams or nightmares? Yes No

If yes, what is the theme? _____

What position does your child sleep in? _____

GENERAL STATUS

Listed below are factors which may or may not influence your child's state of being. Please mark the appropriate box signifying their influence on your child in general if applicable.

BETTER WORSE

- Winter.
- Summer.
- Cold.
- Dampness.
- Sun.
- Open air.
- Change of weather.
- Ocean seashore.
- Physical exertion.
- Morning.
- Evening.
- Bath.
- Warm applications.
- Touch.
- Presence of strangers.

BETTER WORSE

- Spring.
- Autumn.
- Heat.
- Storms.
- Wind.
- Confined (stuffy) air.
- Moonlight.
- Mountains.
- Upon rising.
- Afternoon.
- Night.
- Cold applications.
- Travelling.
- Being consoled.
- _____ Other.

Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to your child NOW or in the PAST.

| NOW | PAST | | NOW | PAST | |
|-----|------|--|-----|------|-------------------------------------|
| ___ | ___ | Anxiety. | ___ | ___ | Memory difficulty, forgetting. |
| ___ | ___ | Restlessness. | ___ | ___ | Mental confusion. |
| ___ | ___ | Crying spells. | ___ | ___ | Decr. concentration, comprehension. |
| ___ | ___ | Depression. | ___ | ___ | Make many mistakes. |
| ___ | ___ | Despair/discontent. | ___ | ___ | Shy, timid. |
| ___ | ___ | Mood swings. | ___ | ___ | Critical of self. |
| ___ | ___ | Suicidal attempts. | ___ | ___ | Critical of others. |
| ___ | ___ | Loneliness/feel alone. | ___ | ___ | Lack of self-confidence. |
| ___ | ___ | Intimate with others. | ___ | ___ | Suspiciousness/jealous. |
| ___ | ___ | Prefer to be with company. | ___ | ___ | Sensitive to noises. |
| ___ | ___ | Prefer to be left alone | ___ | ___ | Organized, neat/clean. |
| ___ | ___ | don't seek out company. | ___ | ___ | Affectionate. |
| ___ | ___ | Afraid when left alone. | ___ | ___ | Assertive, powerful. |
| ___ | ___ | Would rather be alone when not feeling well. | ___ | ___ | Confident, secure. |

Child's Development and Behavior

Is/Was your child's physical development: Slower than average Average Faster than average

Teething: Early Average Difficult

Walking: Early Average Late

Talking: Early Average Late

Mental/emotional development: Slower than average Average Faster than average

How is your child's behavior/attitude and performance at school?

How is your child's behavior/attitude and performance at home?

Describe your child's social interaction with:

Siblings: _____

Other children: _____

Adults: _____

Strangers: _____

In a paragraph, write a short description of your child as he/she is currently. Include strengths, weaknesses, major personality characteristics.

Anger: What makes your child angry? _____

Does he/she get angry often/easily? _____

Does he/she experience uncontrollable rage? _____

Does he/she have difficulty expressing anger? _____

How does he/she express anger? _____

Sadness: What makes your child sad? _____

Does he/she cry when sad? _____

Does he/she cry easily/often? _____

Grief: List major experiences of grief/loss in your child's life.

Fears: Is your child fearful of anything such as: animals, snakes, rodents, people, being alone, robbers, ghosts, sudden noise, thunder, the unknown, heights, closed in spaces, failure, of doing new things, speaking in front of the class, being thrown up in the air and caught, falling, etc.? Are any unmanageable?

THANKS FOR YOUR CO-OPERATION, PATIENCE AND THOROUGHNESS!