Naturally Well Naturopathic Clinic

2211 Riverside Drive Suite 201, Ottawa, ON, K1H 7X5
Tel.: (613) 526-4134 Fax: (613) 526-4180

Please bring this fully completed form to your first visit

Child's Name: _____ Date:_____

Child's Age: _____ Date of Birth ____/____/____
(M) (D) (Y)

Parent's Name:_____

Address: _____
(street, apartment number)

_____
(city, town) (province, state) (postal code, zip code)

Parent's Telephone Number (residence)_____ (work)_____

Email address: _____

Referred by _____

MISSED or CANCELLED APPOINTMENT POLICY
When an appointment is booked, that time is reserved for you. There is usually a lengthy waiting list, so if you have to cancel or reschedule, please notice so that your scheduled time can be booked with another patient. Without proper notification, there will be a charge for missed appointments.

Child's Pediatrician/Family Medical Doctor _____

Chiropractor _____

Other Primary Care Givers _____

What is your primary concern about your child's health?

_____

Other Naturopathic Doctors consulted _____

_____

Secondary Insurance Company (if it gives naturopathic coverage)_____

____

_____

_____

____

What else would you like to see changed in his/her health?

_____

_____

_____

_____
_____
_____

Has a diagnosis been made regarding your child's primary health concern? Yes____ No____
If yes, by whom? Pediatrician____ A Specialist_____ Other _____

Mother's Pregnancy, Child's Birth and Infancy

Describe the general health of both parents prior to conception.

Mother_____
__
_____
__
_____
_____
____

Father_____
__
_____
__
_____
_____
____

Describe the physical health of the mother during the various stages of pregnancy.

_____
__
_____
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_____
__
_____
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_____
__
_____
__
_____
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_____
__
_____
__
_____
__

_____
__

What food supplements did the mother take during the pregnancy?

_____
_____
_____

Did the mother smoke during the pregnancy? Yes_____ No_____
If yes, how many cigarettes per day? _____

Was alcohol consumed by the mother during the pregnancy? Yes_____ No_____
If yes, indicate beverage, amount and
frequency_____
_____

Please list any medications the mother was on during pregnancy

Prescribed:_____
_____
_____

Over the Counter:_____
_____
_____

What was the mother's emotional state during pregnancy?
Stable_____ Stressed_____ Very Stressed_____

If the mother was stressed (or very stressed) what situations were responsible for the stress, and how did she feel about these situations?

_____
_____
_____
_____
_____
_____

Were there any traumatic events during the pregnancy (physical, mental, emotional)? Please describe and indicate at what stage of the pregnancy this occurred._____
_____
_____
_____
_____

_____

Describe the birth of this child? Please indicate if there were any complications._____

_____
_____
_____
_____

_____
_____

Was the baby breast-fed after birth? Yes_____ No_____
If yes, for how long was the baby nursed?_____

What was the first liquid, apart from water, introduced to the baby other than breast milk?_____
_____

What solid foods were started prior to six months of age?

Foods	At what month
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What additional foods were introduced from 6 months of age to 9 months of age?

Foods	At what month
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did the baby have an averse reaction to any food or liquid that was introduced? If yes, which ones?
_____
_____
_____
_____

Did the baby ever have colic?
Never_____ Occasionally_____ Often_____ Severe_____

Describe the baby's health during the first 6 months.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

Child's Profile and Health History

Family Structure and Environment

Are this child's parents: Married____ Common Law____ Separated_____
Divorced_____ Remarried_____

Are there any brothers and/or sisters?

Name	Age	State of Health/Health Concerns
_____	_____	
		_____
_____	_____	
		_____
_____	_____	
		_____
_____	_____	
		_____

Describe the emotional climate of the child's home presently?

_____

_____
_____
_____
_____
_____
_____

Does any member of the household smoke? Yes____ No____

What form of heating do you presently have?
Oil_____ Electrical_____ Gas_____

Child's Development and Behavior

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_____

Was your child's mental/emotional development:
Slower than Average_____ Average_____ Faster than Average_____

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

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

Describe your child's social interaction with:

Siblings_____
_____
_
_____

Other Children_____

_____

_____

Adults_____

_____

_

_____

Strangers_____

_____

_____

Is your child fearful of anything such as (please circle); animals, snakes, rodents, people, being alone, robbers, ghosts, sudden noises, thunder, the unknown, heights, closed in places, failure, of doing new things, speaking in front of the class, being thrown up in the air and caught, falling etc.
Describe_____

_____

_____

_____

Sleep Patterns

Describe the sleep patterns of your child.

_____

_____

_____

What position does your child usually sleep in?

_____

_____

What is the typical mood of your child when he/she wakes in the morning?

_____

_____

Does your child ever have nightmares (night terrors)?

_____

_____

Does your child ever tell you about the dreams he/she has? If yes, please describe_____

_____

_____

Describe your child's nature and temperament. It is important for both parents to make their observations.

Father's Observations

Mother's Observations

Describe any behaviors, attitudes or mannerisms that are relatively unique to your child. (What makes him/her different from his/her siblings or friends.

Child's Health History

What childhood diseases have your child had? Indicate if it was mild, average or severe.

	Yes/No	Age	Severity
Roseola		_____	_____
Rubella (German Measles)		_____	_____
Rubeola (Measles)		_____	_____
Chicken Pox		_____	_____
Mumps		_____	_____
Scarlet Fever		_____	_____

Pertussis (Whooping Cough)

Strep Throat

Impetigo

Mononucleosis

Fifth's Disease

Pneumonia

What was your child's first illness that was given medical attention?

Illness Age Treatment

_____

List all medications your child has taken in the past. If antibiotics please give type.

Age Illness
Medication Adverse
Reaction?

_____
_____
_____
_____
_____
_____
_____
_____
_____

What medications is your child on at this time._____
_____
_____
_____

How many times has your child been treated with antibiotics?

_____

What vaccinations has your child had?

Vaccination Age Adverse
Reaction (?)

_____
_____
_____
_____
_____
_____

_____
_____

What food supplements does your child take on a regular basis?_____
_____

Does your child have any known food allergy/intolerances? _____
_____

Does your child have any known environmental allergies? _____
_____

Please give a brief history of the present health concern, giving age of onset, first symptoms, and present symptoms._____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Did any stressful situation, event, trauma, frightful experience or acute illness precede the onset of the health concern?
_____
_____
_____
_____
_____
_____
_____
_____
_____

Food Cravings and Thirst

List all foods your child appears to crave._____
_____

_____

List all foods your child does not like._____
_____
_____

List all foods your child refuses to eat._____
_____
_____

What of the following tastes does your child seem to crave:
Salty _____ Sweet_____ Sour _____ Bitter _____ Spicy _____

Does your child like the taste of fat/fatty foods? _____
_____

Describe (list) the typical diet of your child based on a normal day, including snacks, beverages and glasses of water.

A.M. _____
_____
_____
Noon/Afternoon._____
_____
_____
Evening _____
_____
_____

Body Temperature and Perspiration

Is your child warm blooded (needs few clothes) or cold blooded (tends to get chilly easily)? _____

_____

Does your child perspire easily? Yes____ No____

What are the parts of his/her body that perspire the most? _____
_____
_____

Does the perspiration stain the child's clothing? _____

Does the perspiration have a strong odor? _____

Family History

Please put an "L" for living and a "D" for deceased. Age is present age or age at the time of death.

Relationship	L/D	Age	Diseases Suffered / Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			

Relationship	Diseases Suffered
Paternal Uncles	
Paternal Aunts	
Maternal Uncles	
Maternal Aunts	
Brother/Sister (1)	
(2)	
(3)	
(4)	

Indicate if there have been any of the following diseases in Grandparents, parents, or brothers and sisters. Indicate the number of relatives who have had the disease.

Diabetes_____ Cancer_____Heart Disease_____ Mental Illness_____ Asthma_____
Alzheimer's Disease_____ Tuberculosis_____Arthritis_____ Hypertension_____
Allergies_____ Goiter_____Rheumatism_____ Kidney Disease_____Stomach Disorders_____

Do either the child's mother or father have a chronic illness? What is their general state of health?

Mother_____
_____
_____
_____

_____

Father_____

_____
_____
_____
_____

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your child's present health concerns and will assist us in choosing an appropriate direction for his/her restoration to health.