Naturally Well Naturopathic Clinic

804 Greenbank Rd., Nepean, ON K2J 1A2
Tel. 613-825-2524

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(s): _____

Address: _____
(street, house/apartment number)

_____
(city/town) (province) (postal code)

Parent's telephone number: (home) _____ (work) _____

Parent's email address: _____

Referred by: _____

Child's Pediatrician/Medical Doctor: _____

Chiropractor: _____

Other Primary Care Givers: _____

Secondary Insurance Company (if it has Naturopathic coverage): _____

Missed or Cancelled appointment policy

When an appointment is booked, that time is reserved for you and your child. There is usually a lengthy waiting list. If you have to cancel, we require 48 hours notice so that your scheduled time can be given to another patient. Without proper notification, there will be a charge for missed appointments.

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

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

Has a diagnosis been made regarding your child's primary health concerns? Yes: _____ No: _____
If yes, by whom? Pediatrician: _____ Specialist: _____ Other: _____

Mother's Pregnancy, Child's Birth and Infancy

Describe the general health of the both parents prior to conception.
Mother _____
_____
_____
_____
Father _____
_____
_____
_____

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

What food supplements did the mother take during pregnancy? _____
_____
_____
_____

Did the mother smoke during 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 pregnancy; physical, mental and/or 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? _____

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? (please list food name and at what month)
_____
_____
_____
_____

What additional foods were introduced from 6 months of age to 9 months of age? (please list food name and at what month)
_____
_____
_____
_____

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

Did the baby every 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 the child's parents: Married _____ Common Law _____ Separated _____ Divorced _____ Remarried _____

Are there any brothers and/or sisters? (please list name, age and state of health)
_____
_____
_____
_____

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 Behaviour

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

Was your child's teething: Early _____ Average _____ Difficult _____

Was your child's walking: Early _____ Average _____ Late _____

Was your child's 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 your child's behavior, attitude and performance at home?
_____
_____
_____
_____

Describe your child's social interaction with:
Siblings: _____
_____
_____
_____
Other Children: _____
_____

_____
_____
Adults: _____
_____
_____
_____
Strangers: _____
_____
_____
_____

You're your child fearful of anything such as: (please circle all that apply)

animals | snakes | rodents | people | being alone | robbers | ghosts | sudden noises | thunder | the unknown |heights | closed in spaces | failure | doing new things | speaking in front of the class | being thrown in the air and caught | falling| anything not on the list

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 or night terrors?
_____
_____
_____

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

Temperament

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 behaviours, attitudes or mannerisms that are relatively unique to your child:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Child's Health History

What childhood diseases has your child had? Please check and Indicate if it was mild, average or severe and their age.

__ 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? Please include illness, age and treatment.
_____
_____

List all medications your child has taken in the past. If antibiotics, please include type. Please include illness, age, medication name and if there was an adverse reaction.
_____
_____
_____
_____
_____
_____

Is your child on any medications at this time? Please list all.
_____
_____
_____

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

What vaccinations has your child had? Please list vaccination name, age given and any adverse reactions.
_____
_____
_____
_____
_____

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

Does your child have any known food allergies or intolerances? _____
_____
_____
_____

Does your child have any known environmental allergies? _____
_____
_____
_____

Please give a brief history of the present health concern, including 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 tast of fat/fatty foods? _____

Describe (list) the typical diet of your child based on a normal day, including snacks, beverages and glasses of water.
Morning _____
_____
_____
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 circle an "L" for living and "D" for deceased. Age is the present age or age at time of death.

Paternal Grandfather: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Paternal Grandmother: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Maternal Grandfather: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Maternal Grandmother: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Father: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Mother: L / D Age _____ Diseases Suffered/Cause of Death _____
_____

Paternal Uncles: Diseases Suffered _____
_____

Paternal Aunts: Diseases Suffered _____
_____

Maternal Uncles: Diseases Suffered _____
_____

Paternal Aunts: Diseases Suffered _____
_____

Brothers: Diseases Suffered _____
_____

Sisters: Diseases Suffered _____
_____

Indicate if there have been any of the following diseases in Grandparents, parents, brothers or sisters. Also 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.