NATUROPATHIC HEALTH EVALUATION FORM –CHILD

Please take the time (allow 30 mins) to thoroughly and thoughtfully complete your naturopathic health evaluation form and submit it back to the clinic 24 hours prior to your first appointment . This information will be kept strictly confidential.

General Information

Name: ________________________ Age: _____ Date of birth: ________ Sex:____
Height: __________________ Weight: ___________________ Grade level: ________
Address:
____
City: _____________________________ Postal Code: ___________________________
Phone numbers: (H) __________________ (W) ____________________________
Parent/Legal guardian:
____
Email:
____
How did you hear about our Clinic (e.g. website, word of mouth, walking by)?
Were you referred by anyone? Y/N – If yes, by whom?
Has the child ever seen a naturopathic doctor before? Y/N – If yes, whom? How long ago?

Emergency Contact

Name and relation to child: ____
Address: ____
Phone: (home) ________________________ (work) _____________________________
With whom does the child currently live? ____

Other Health Care Providers

1. Name: ____
Designation (e.g., pediatrician, family physician, etc.): ___________________________
Address:____ Phone: _______________

2. Name: ____
Designation: ____
Address:_______________________________________ Phone:____________________

Health Concerns
1. Primary health concern:____
At what age did this condition/illness begin? ________________________________
Has this condition occurred before?____
Does anything make the condition better or worse? ___________________________
____
Prior treatments if any and outcomes of the treatments_________________________
____
Other health concerns:
2.____

3.____

Medical History
How would you describe your child's general stare of health?(please circle)
Excellent Good Fair Poor

Date of last complete screening physical examination________________

Has your child ever experienced any of the following illnesses?
□ Rubella □ Mumps □ Measles □ Chickenpox □ Pertussis □ Diphtheria □ Small pox
□ Scarlet Fever □ Polio □ Typhoid □ Mono □ Rubeola □ Meningitis
□ Other:_______________

Does the child have any allergies to drugs, foods, environment, animals or other?
____
____
Please list any previous hospitalizations or
surgeries____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)
____
____
____
____
____
____
Please list all past medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)
____
____
____
____
____
____

Please indicate the immunizations your child has had and when:

DPT (Diphtheria, Pertussis, Tetanus)__________
Polio ________
MMR (Measles, Mumps, Rubella) __________
TB ________
Haemophilus influenza B __________
Flu ________
Smallpox __________
Chickenpox ________
Pneumovaccine __________
Hepatitis A ________
Hepatitis B __________
Did your child have any reactions or complications with the above indicated vaccines?
____

What screening tests has your child had (blood, hearing, vision, etc.)?
____
____

Family Health History

Have any blood related family members ever suffered from (please indicate who):
□ Allergies □ Arthritis □ Asthma □ Anemia □ Cancer □ Cataracts □ Diabetes □ Eczema
□ Genetic disorders □ Heart attack □ Hypoglycemia □ High blood pressure
□ Mental Illness □ Seizures □ Sickle cell anemia □ Stroke □ Thyroid condition
Other:____
____

Prenatal Health and History

How was the health of the parents at conception?(please circle)
Mother: Excellent Good Fair Poor Unknown
Father: Excellent Good Fair Poor Unknown
What was the mother's age at the child's birth? ________________________________
How was the mother's health during the pregnancy?
Excellent Good Fair Poor Unknown
How was the mother's diet during the pregnancy?
Excellent Good Fair Poor Unknown
What was the mother's level and type of exercise during pregnancy?
____
____
Did the mother experience any of the following during the pregnancy?
Bleeding Nausea Vomiting High blood pressure Diabetes Thyroid problems
Physical or Emotional trauma
Other:____

Did the mother use any of the following during the pregnancy?
Tobacco Alcohol Recreational drugs:
____
Prescription medications:____
Over-the-counter medications:______________________________________
Supplements:____
____
Other:____
____
Was the mother exposed to any of the following during the pregnancy?
Diseases:
____
Toxins:
____
Other:
What was the mother's mental status during the pregnancy?
____
____
____

Birth History:
Number of pregnancies: __________ Number of miscarriages: ____________
Term length with this child: Full Premature: _________wks
Late: ________wks
Length of labour: _______ Weight at birth: _________ Height at birth: __________
Head Circumference: _______
Apgar score: 1 Minute________ 2 Minutes_________ 5 Minutes________
Any complications during the delivery? ______________________________
Location of birth: Hospital Home Birthing Center Other:_______________
Was the birth: Vaginal C-section Induced Forceps
Anesthesia/ Epidural used Episiototomy
Mother's emotional status at the time of birth? __________________________________
Mother's emotional status post-partum?
Did the child experience any of the following at or shortly after birth?Jaundice Rashes
Seizures Respiratory distress Infections Colic AnemiaBirth injuries/defects:
____
In general, how was your child's health in the first year?
Poor Fair Good Excellent Unknown

Diet
Breast fed. How long?
____
Formula (type):____
Other:____
Did your infant experience any difficulties with the formula or breast milk? ___________

When was solid food introduced?______What foods were first introduced? Please indicate the age that the foods were introduced and if there were any reactions to the foods.

____
____
____
____

Describe a typical day's diet for your child? (Approximate quantities)
Breakfast____
Lunch ____
Dinner ____
Snacks ____
Beverages____
Please describe your child's eating habits (ie. picky eater, large appetite etc.).

Please list any food sensitivities or intolerances (e.g. dairy, soy, wheat, gluten, corn, eggs, etc) that you are aware of.

Review of Systems
Please indicate any of the following conditions your child now experiences or has in the past:
□ Ear Infections □ Asthma or Allergies □ Colic □ Bronchitis □ Frequent Colds/Flu
□ Strep throat □ Pneumonia □ Visual problems □ Heart problems □ Scoliosis □ Seizures
□ Headaches □ Digestive Problems □ Sinus Problems □ Recurring Fevers □ Bed Wetting
□ Back/neck Pains □ Dental Cavities □ Temper Tantrums □ Constipation/Diarrhea
□ Growing Pains □ Dizziness □ Abdominal pain □ Broken Bones □ Hernias □ Easy bruising □ Undescended testes

Bowel Movement frequency ____
Bowel Movement appearance____

Has your child ever had any significant physical or emotional traumas? ______________
____
____

Development
Please indicate at what age your child began the following:
Teething ___________ Sitting ___________
Crawling ___________ Walking __________
Talking ___________ Potty training _____
Were there problems associated with any of the above mentioned stages?
____
____

Sleep
What time does your child usually go to bed? ___________________________________
What time does your child usually wake in the morning?__________________________
Does your child nap during the day? Yes No What time(s): ______________________
Does your child have nightmares? Yes No How often? _________________________
Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, etc.)? ____
____

Social/Environmental
Is the child in: school daycare home care other
____
What are your child's favorite activities?
____
____
____
___
How would you describe your child's temperament?
____
____
Does the child exercise regularly? Y N How much, how often?
____
____
How much television does your child watch? __________________ hrs a day/week
How often does your child read (not for school), or how often does someone read to your child?
□ Daily □ Several times a week □ Weekly □ Less than weekly
Does anyone in the child's household smoke? Y N
Are there animals in the home? Y N
How is the child's home heated?
□ Natural Gas □ Oil □ Electric □ Wood □ Other
____
Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.
____
____
____
____
____
____
____
How would you describe the emotional climate of the child's home?
____
____
____

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

____
____
____

If you have any concerns (e.g. time commitment, significant financial restrictions) please note them here:

THANK YOU for investing your time in completing this health care evaluation. Please submit your form back to Norfolk Wellness 24 hours before your initial consultation.