BROOKLIN
NATUROPATH

Pediatric Patient Information Form

Last Name:		First Name:		Middle Name:
Date of Birth (MM/DD/YYYY):	Age:	Sex: F / M	Who is filling out this form? (name, relationship)	
Contact Information				
Full Address:			City, Province:	
Postal Code:	Daytime phone number:	Evening phone number:	May we leave messages regarding your visit: Yes / No	
Email:				
Emergency Contact Information				
1) Last Name:		First Name:	Relationship:	
Daytime phone number:		Evening phone number:		
2) Last Name:		First Name:	Relationship	
Daytime phone number:		Evening phone number:		
Other Healthcare Providers				
1) Name: Specialty/Focus: Phone number:		2) Name: Specialty/Focus: Phone number:	3) Name: Specialty/Focus: Phone number:	
Date of last medical doctor visit:		Date of last physical exam:		
Please list regular screening tests performed by other physicians:				

How did you hear about this clinic?	
If referred, please state by whom:	
Have you been treated by a Naturopathic Doctor before? Yes / No	
If yes, by whom?	Date of last visit to ND:

Pediatric Health Assessment Questionnaire

In your opinion, what are the child's most important health concerns:
1)
2)
3)
4)
5)

Medical History	
Was the child adopted? Yes / No	**Does the child receive regular age-specific screening exams?** (hearing, vision, height, weight, etc) Yes / No
Current Height:	**Current Weight:**

Vaccination / Immunization Record: Check all that apply

Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

☐ **DPT** (Diptheria, Pertussis, Tetanus)
☐ **MMR (**Measles, Mumps, Rubella)
☐ Gardasil/Cervarix (HPV Vaccine)
☐ Haemophilus influenza B
☐ BCG (Tuberculosis)
☐ Hepatitis A
☐ **Hepatitis B**
☐ **Polio**
☐ Flu Vaccine
☐ **Pneumococcal Conjugate** (Meningitis/Pneumonia)
☐ **Meningococcal C Conjugate** (Meningitis)
☐ **Varivax/Varilrix** (Chicken Pox)
☐ Other: _____

Did any of your vaccines cause adverse reactions, if yes:

_____

Which of the following childhood illnesses has the child had? Check all that apply

☐ Asthma
☐ Rheumatic fever
☐ Rubella (German measles)
☐ Chicken Pox
☐ Sinus concerns
☐ Frequent colds
☐ Strep throat
☐ Polio
☐ Scarlet fever
☐ Whooping cough
☐ Mononucleosis
☐ Ear infections
☐ Fractures
☐ Tonsillitis
☐ Mumps
☐ Roseola
☐ Measles
☐ Skin concerns (eczema, etc)
☐ Epilepsy
☐ Frequent nosebleeds
☐ Other:_____

List any previously diagnosed medical conditions:	**Treatment received:**	**Year**
1)		
2)		
3)		
4)		
5)		

List all allergies (medications, foods, supplements, environmental, etc) 1)	**Reaction Type**
2)	
3)	
4)	
5)	

List all prescription drugs (antibiotics, etc)**, over-the-counter medications** (cold/flu formulas, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **the child is currently taking**

Medication	**Dosage**	**Start Date**

Family Medical History					
Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information					
	Age	**Health History**		**Age**	**Health History**
Father			**Mother**		
Grandmother (Paternal)			**Grandmother (Maternal)**		
Grandfather (Paternal)			**Grandfather (Maternal)**		
Siblings		F / M	**Siblings**		F / M
		F / M			F / M

Prenatal History	
Pregnancy weight gain:	**Was the child conceived naturally?** Yes / No
If fertility interventions were used, please indicate:	
Mother's age at conception:	**Father's age at conception:**

Did the mother experience any of the following during pregnancy? Check all that apply

☐ Excessive bleeding ☐ Nausea ☐ High blood pressure
☐ Diabetes ☐ Vomiting ☐ Thyroid concerns
☐ Emotional trauma ☐ Physical trauma
☐ Other illnesses:

List all prescription drugs and over-the-counter medications taken during pregnancy:

Medication	Dosage	Start Date

List all herbs and natural supplements taken during pregnancy:

Medication	Dosage	Start Date

Natal (Birth) History	
What type of delivery? Vaginal birth / C-section / Hospital / Home-birth	**Duration of labour:**
Was the labour: Spontaneous or Induced	**If there were difficulties, please describe:**
Were any delivery interventions used? Yes / No **If yes, which ones?** Epidural Episiotomy Forceps Suction	**Was mom Strep B positive?** Yes / No **If yes, were antibiotics used during birth?** Yes / No
Term length: Full / Premature: wks / Overdue: wks	
Birth Weight: **Birth Length:**	**Apgar score: 1min:** **5min:**

Did the baby experience any of the following at or after birth? Check all that apply

☐ Jaundice ☐ Birth injuries
☐ Seizures ☐ Congenital conditions:_____
☐ Rash
☐ Infections ☐ Colic
☐ Respiratory distress ☐ Poor feeding
☐ Other illnesses:

Were any of the following interventions used: Silver nitrate drops / Vitamin K drops / Other

Dietary and Lifestyle Habits		
Nutrition and Feeding	Was the child breast-fed? Yes / No	If yes, for how long?
	Was the child formula fed? Yes / No	If yes, when did he/she start?
	When was solid food 1st introduced?	Please list the 1st foods introduced:
	Does the child follow a specific diet regime? Vegetarian / Vegan / Other	
	On average, how many meals does the child have in a day? 1 2 3 4 5 >5	
Sleeping and Resting	How many hours of sleep does the child get?	Does the child nap? Yes / No
	Does the child have trouble falling asleep? Yes / No	What keeps him/her up?
	Does the child sleep through the night? Yes / No	If no, how often does he/she wake up?
	Child's usual sleep time:	Child's usual wake-up time:
	Does the child: wet the bed / snore / have nightmares / sleep walk / talk in their sleep	
Development and Social History	Describe how the child interacts with siblings / friends:	
	Does the child exercise regularly? Yes / No	If yes, what type?
	In a typical day, how long does the child: Watch TV: Play games: Use computer:	
	At what age did the child first: Sit up: Crawl: Walk: Talk: Teeth: Toilet Train:	

Is there any other important information that you would like me to know?

_____
_____
_____
_____
_____