Port Moody Naturopathic Clinic
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Child Health Intake Questionnaire

Child's name_____ Age:____ M□ F□ Adopted: Y□ N□
Today's date:_____ Birth date:_____
Parent(s)/Guardian(s)/Caretaker Name(s)_____
Occupation (s)_____

Address:_____ Phone (H)_____
_____ (W)_____
_____ Email address_____
Emergency Contact_____ Phone_____
Relationship_____ Email_____

Family Medical History: Please check relevant areas for blood relatives (not child)

□ Asthma	□ Epilepsy	□ Mental Disorders
□ Arthritis	□ Gout	□ Obesity
□ Bleeding Problems	□ Hayfever, Allergies	□ Stroke
□ Cancer	□ Heart Problems	□ Substance abuse
□ Diabetes	□ High Blood Pressure	□ Tuberculosis
□ Eating Disorders	□ Kidney Problems	□ Thyroid Problems

Main Health Concern(s)

What health concerns/problems brought you into the office today? If he/she has a specific condition, please describe it in detail.

How long has this been troubling your child?

Has anything recently changed or become worse?

In order of importance, list other health concerns that are troubling your child:

1)_____ Since when?_____
2) _____ Since when?_____
3) _____ Since when?_____
4) _____ Since when?_____
Other concerns:_____

Describe any factors you suspect may have played a role in it's onset and/or it's continuation.

List all medications, supplements, herbs, and homeopathic medicines your child is currently taking (include dosage and results):

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List any treatments your child has had for this condition (surgery, acupuncture, massage, etc) and the results. Please include dates:

If your child has been treated homeopathically in the past, please list the remedies taken, at what dose (strength and frequency), and with what results:

Your child's general state of health is: excellent good average fair poor

Prenatal History

What was the level of health of both parents at the time of conception? (circle)
Mother: excellent good fair poor
Father: excellent good fair poor

What was the state of health of the mother during pregnancy? Excellent good fair poor

Was this a planned pregnancy? (yes/no) If not, what type of birth control was used?____

Did the mother have any of the following during pregnancy (circle):
Trauma (any kind) chicken pox toxoplasmosis rubella
Chlamydia HIV genital herpes syphilis
Strep infection severe nausea hypertension diabetes
Hypothyroidism hyperthyroidism eclampsia depression
Other:_____

List any supplements, medicines, herbal medicines, and homeopathic medicine taken by the mother during pregnancy:_____
_____

Natal history

How/where was your child delivered? (Circle)
Home birth hospital birth vaginal delivery C-section breech head-first

Were there any interventions during the child's birth? (Circle)
Induction (any type) vacuum extraction forceps epidural pain control

Length of pregnancy in months:_____ Length of labour in hours:_____

Birth weight:_____ Mother's age at birth: _____ APGAR score: _____

List any complications not covered above: _____
_____

Neonatal history

Did your child have any of the following in the first year of his/her life? (Circle)

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Birth defects	Anemia	Respiratory problems
Jaundice	Rashes	Allergies
Birth Injuries	Convulsions	Ear Infections
Colic	Lack of appetite	Other:_____

After the first year

Childhood illnesses (Circle):

Chicken pox	Measles	Mumps	Impetigo	Diarrhea
Polio	Strep throat	Scarlet fever	Allergies	Eczema
Lice	Pink eye	Tonsillitis	Tuberculosis	Colic
Constipation	Pneumonia	Croup	Diaper rash	Vision loss
Asthma	Cradle cap	Nose bleeds	Hearing loss	Hypothyroidism
Bed wetting	Ear infections	Anemia	Hyperactivity	Chronic infection
Depression	ADD/ADHD	Autism	Cancer	Oral herpes
Crohn's disease	Ulcerative colitis		Epilepsy	Hypoglycemia
Diabetes	Warts	Heart disease	Heart attack	Canker sores
Hypertension	Hepatitis	Whooping cough		Mononucleosis
Rubella	Diphtheria			

Please list the most significant, stressful events in your child's life. Are any of these situations continuing to impact his/her life? (If so place a star next to the event)

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____

Previous surgeries and hospitalizations not mentioned above (include dates) _____
_____

Does your child have any allergies to any drugs, herbs, foods, animals, or other? Please list:
_____

Nutrition History

Was your child bread fed? (yes/no) Until what age?_____ Any problems?_____

If formula was used, which one was it? _____ Any problems?_____

Food Introduction

Please list foods introduced, in the order of introduction, with age and any reactions you noticed (use back of page if more space is needed).

Foods introduced	Age	Reaction(s)