Renée Isaacs Langdon, BSc (Hons), MSc, ND

CCNM Integrated Healthcare Centre, 1255 Sheppard Avenue East
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CONTACT INFORMATION

Last name: ____________________________ First name___________________ Date:_____________

Date of Birth: ___________ /____________/__________ Age: _____ Sex: □ F □ M
Month Day Year

Marital Status: S M D W Sep Occupation: ___________________________________

Full Address: ____ Suite #_________________

City:__________________________ Province:____________________ Postal Code:______________

Telephone: (Home) _____________________________ (Work) ____________________________

Email address:____

Information can be conveyed through: □ Mail(newsletters, brochures etc.) □ Email □ Telephone

Chief Health Concerns: ____

____

Name of Medical Doctor: _____________________________ Telephone: _______________________

Date of Last Physical: ________________________

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? ____________________________________ When? ____________________

Other Health Care Providers you are seeing

1. ____ Tel: ___________________________

2. ____ Tel: ___________________________

3. ____ Tel: ___________________________

In Case of Emergency

Contact Name: ____

Telephone: (H)___________________ (W)_________________ Relation: _______________________

Signature: ____ Date:________________________

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PAEDIATRIC HEALTH ASSESSMENT QUESTIONNAIRE

1. GENERAL INFORMATION

Last name: ___________________________ First name__________________ Date:_____________

Date of Birth: ___________ /____________/__________ Place of birth:_____________________
Month Day Year

Age: _______ Gender: □ F □ M Race/ethnic origin: ____________________

Height: ______ feet _____ inches or _____ centimetres Weight: _________lbs or ________ kg

Was child adopted?: □ Yes □ No

Who is filling out this form?______________________________ ___________________________
Name Relationship to child

No. of persons in household: _______ Relationship to child _____________________________

No. of siblings: Males______ Females_____

Parental Status: □ Single □ Married □ Divorced □ Separated □ Common Law □ Widow/Widower

No. of pets in household: __________ What type of pets? ______________________________

In your opinion, what are the most important health concerns/chief complaints?

1.______________________________________ 5. ____________________________________

2. ______________________________________ 6. ____________________________________

3. ______________________________________ 7. ____________________________________

4. ______________________________________ 8. ____________________________________

Others: ____

Which of the above problems are of the most immediate concern to you? _________________________

____

Are there any traumatic events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravate your health problems? ____

____

____

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2. MEDICAL HISTORY

How would you describe the general state of health of the child? □ Poor □ Fair □ Good □ Excellent

Immunizations	Age	Adverse Reactions
DPT		
MMR		
Tetanus		
Polio		
Haemophilus influenza B		
Hepatitis B		
Hepatitis A		
« Flu »		
Other:		

Surgeries/Procedures/ Hospitalizations	Date	Accidents/Illnesses	Date
Abdominal/Gastrointestinal		1.	
Appendectomy (appendix)		2.	
Cancer (type):		3.	
Gallbladder		4.	
Heart		5.	
Sinuses			
Tonsillectomy (tonsils)			
Tubes in ears –1st set			
Tubes in ears – 2nd set			

Other traumatic events (please specify type and date): ____

____

Which of these illnesses/conditions has the child had?

□ Asthma/Wheezing □ Chicken Pox □ Epilepsy/fits □ Impetigo
□ Mononucleosis □ Measles □ Mumps □ Polio
□ Rheumatic Fever □ Scarlet Fever □ Roseola □ Fractures
□ Rubella (German measles) □ Sinus problems □ Whooping cough □ Nosebleeds
□ Headaches/migraines □ Ear infections □ Allergies______________________
□ Skin problems (eczema, psoriasis etc.) ____
□ Other____

pt.: ____ **DOB:** ______________

3. FAMILY MEDICAL HISTORY

Please indicate if any of child's immediate family (mother, father, maternal/paternal grandparents, siblings, aunts, uncles) has ever had any of the following health concerns:

Health Concern	Family Member	Health Concern	Family Member
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer's		Intestinal Disease	
Anemia		Kidney Disease	
Arthritis		Learning Disability	
Asthma		Mental Illness	
Birth Defects		Migraine headaches	
Bleeding (easily)		Neurological Disorders	
Cancer (Specify type)		Obesity	
Diabetes		Osteoporosis	
Drug Addiction		Sickle Cell Anemia	
Eczema		Stroke	
Epilepsy/Seizure		Suicide	
Genetic Disorder		Thyroid (hyper/hypo)	
Glaucoma		Tuberculosis (TB)	
Gout		Venereal Disease (STDs)	
Heart Disease		Other:	

4. PRENATAL INFORMATION (DURING PREGNANCY)

Mother's health at conception: □ Poor □ Fair □ Good □ Excellent □ Unknown

Father's health at conception: □ Poor □ Fair □ Good □ Excellent □ Unknown

Mother's age at conception:________ Father's age at conception:________

Mother's health during pregnancy: □ Poor □ Fair □ Good □ Excellent □ Unknown

Mother's diet during pregnancy: □ Poor □ Fair □ Good □ Excellent □ Unknown

Parental allergies/food sensitivities:____

Was the mother exposed to any of the following during pregnancy?

□ Alcohol □ Caffeine □ Tobacco □ Street drugs/narcotics___________________________

□ Prescription medications:____

□ Over the counter medications:____

□ Supplements:____

□ Other____

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Did the mother experience any of the following during pregnancy?

□ Hypertension □ Pre-eclampsia □ Vomiting □ Nausea

□ Diabetes □ Thyroid problems □ Bleeding □ Physical or emotional trauma

□ Other (specify)____

Mother's cravings:____

Mother's dislikes:____

Parental stresses (check all that apply): □ Physical □ Mental □ Emotional □ Spiritual

Did Mother: □ Sing to child □ Read to child □ Talk to child □ Work □ Exercise

Mother's sleep patterns:____

5. NATAL (BIRTH) INFORMATION

Location of birth: □ Home □ Hospital □ Birthing centre □ Other_______________

Duration of labour:_____________ Birth order:________ Time of birth:__________

Type of birth: □ Vaginal □ Caesarean □ Normal presentation □ Breech presentation

□ Other presentation (specify)_______________________________

Pregnancy term at birth: □ Full Term □ Pre-term:________wks. □ Post term:________wks.

Complications: □ No □ Yes; Please specify_______________________________

Interventions used: □ No □ Yes; □Forceps □Suction cap □Anaesthesia used □Induced birth

□ Other (specify)____

Mother's experience at birth: □ Good □ Bad □ Other_________________________

6. POSTNATAL (AFTER BIRTH) INFORMATION

Birth weight:_________ Birth length:_________ Head circumference:_________

Apgar Score: Heart rate___ Colour___ Respiration___ Reflex irritability____ Muscle tone___

Interventions: □ Silver nitrate drops □ Vitamin K drops □ Other (specify)____________________

Newborn problems: □ Jaundice □ Colic □ Heart □ Lungs □ Congenital______________

□ Other____

Feeding History:

How was the infant fed?

□ Breast fed How long?_________

□ Formula Type?_________ Age started____ Adverse reaction: □ No □ Yes_______________

□ Other____

□ Solid food Age started____ What given 1st______________ Reaction___________________

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Please indicate the number of times per week that child eats or drinks the following:

Food	Times/wk	Food	Times/wk	Food	Times/wk
Fruits/Fruit juices		Milk/Cheese products		Candies/Sweets	
Vegetables/Vegetable juices		Soy/Rice/Almond milk		Sweetners	
Meat		Soft Drinks (regular)		Condiments	
Nuts/Seeds/Legumes/Beans		Soft drinks/Pop (Diet)		Wine	
Grains (rice, millet, breads etc)		Coffee		Other alcoholic	
Oils (butter, margarine, etc.)		Tea		Bottled water	
Spices (Garlic, thyme etc.)		Herbal tea		Tap/filtered water	

On average how many meals does child eat per day: 1 2 3 4 5 +5

What is child's largest meal: □ Breakfast □ Lunch □ Dinner

List any foods that child craves ____

List any foods that child dislikes ____

Does child follow a specific diet regime? □ Vegetarian □ Vegan □ Other____________________

Do you monitor child's intake of □ Fat □ Salt □ Sugar □ Fibre □ Carbohydrate □ Protein

Is child often thirsty? □ Yes □ No How many glasses of water does child drink in a day? ________

What temperature of drinks does child prefer? □ Hot □ Warm □ Cold □ Room Temperature

Sleep History

Describe child's sleep pattern____

How many hours a day of sleep does child get? _____________ Does child nap? □ Yes □ No

Does child have trouble falling asleep? □ Yes □ No What keeps child up? ____________________

Does child sleep straight through the night? □ Yes □ No If no how often ______________________

Does child: □ Wet the bed □ Snore □ Have nightmares □ Sleep walk □ Talk in sleep

What position does child sleep in? ____

Child's Development & Social History

At what age did child first: Sit up______ Crawl______ Walk______ Talk______ Teethe_____

How would you describe child's personality?____________________________________

What are child's positive traits?____

What are child's negative traits?____

How does child interact with siblings? ____

How long does child: □ Watch TV_______ □ Play video games_______ □ Use computer________

Does child exercise regularly: No Yes Type of exercise__________________ How often?________

What are child's favourite activities____

Please describe child's behaviour and performance at school ?______________________________

____

How does child respond to his/her peers?____

____

How does child express love?____

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What makes child happy? ____
What makes child sad? ____
Does child cry easily/often? □ Yes □ No Does being consoled help? □ Yes □ No
What makes child angry?____
Does child get angry easily/often? □ Yes □ No How does child express anger?______________
____
What fears does child have? ____
List major experiences of grief/loss in child's life____
____
What was the most traumatic experience in child's life? ____
____
Are there any known episodes of physical or sexual abuse in your past? ___________________________
____

Environmental Exposures

Which of the following is child routinely exposed to?

□ Forced Air	□ Radiant Heat	□ Gas Heat	□ Oil Heat	□ Electric Heat
□ Wood Stove	□ Air Conditioning	□ Electric Blanket	□ Television	□ Microwave
□ Feather Pillow	□ Heated Waterbed	□ Computer Screen	□ Gas fumes	□ Pollution
□ Water Pollution	□ Hydro Towers	□ Chemical Sprays	□ Factory	□ Paint fumes
□ Makeup/body creams	□ Perfumes/Colognes	□ Acrylic nails	□ Tobacco smoke	□ Deodorizers
□ Cleaning Products	□ Other (Specify) ______________________			

Is home: □ Brand new □ Old □ Other________ How is the home heated?______________________
Is home near to: □ Electric poles □ Highway □ Airport □ Industrial plant
Does home have: □ Carpets □ Pets □ Mildew □ Current renovation projects
Is child's home or school environment excessively □ Damp □ Moist
Does anyone in the child's household : □ Smoke □ Drink alcohol □ Take recreational drugs

Which of the following are known allergies or are most bothersome to child?

□ Sunshine	□ Dust	□ Dampness	□ Lack of Sunshine	□ Mold	□ Dryness
□ Summer	□ Spring	□ Winter	□ Fall	□ Heat	□ Cold
□ New Moon	□ Full Moon	□ Perfume	□ Tobacco Smoke	□ Car Fumes	□ Dogs
□ Cats	□ Insects	□ Seashore	□ Mountains	□ Tree Pollens	□ Grasses/Weeds
□ Fluorescent Lighting			□ Poor Air Ventilation		
□ Changes of Weather (specify) _______________			□ Approach of Storms		
□ Foods (specify) ___________________________			□ Chemicals (specify) _________________________________		

□ Other (specify) ____

How would you describe the emotional climate of child's home?_________________________________
____
Is there any information not covered above that would be relevant to child's health profile?_____________
____