

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:		2) Name:		3) Name:
Specialty/Focus:		Specialty/Focus:		Specialty/Focus:
Phone number:		Phone number:		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		
<input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Gardasil/Cervarix (HPV Vaccine) <input type="checkbox"/> Haemophilus influenza B	<input type="checkbox"/> BCG (Tuberculosis) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Polio <input type="checkbox"/> Flu Vaccine	<input type="checkbox"/> Pneumococcal Conjugate (Meningitis/Pneumonia) <input type="checkbox"/> Meningococcal C Conjugate (Meningitis) <input type="checkbox"/> Varivax/Varilrix (Chicken Pox) <input type="checkbox"/> 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		
<input type="checkbox"/> Asthma <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Rubella (German measles) <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Sinus concerns <input type="checkbox"/> Frequent colds <input type="checkbox"/> Strep throat	<input type="checkbox"/> Polio <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Whooping cough <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Ear infections <input type="checkbox"/> Fractures <input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Mumps <input type="checkbox"/> Roseola <input type="checkbox"/> Measles <input type="checkbox"/> Skin concerns (eczema, etc) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Other: _____
List any previously diagnosed medical conditions:	Treatment received:	Year
1)		
2)		
3)		
4)		
5)		

List all allergies (medications, foods, supplements, environmental, etc)	Reaction Type	
1)		
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		
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Nausea	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Thyroid concerns
<input type="checkbox"/> Emotional trauma	<input type="checkbox"/> Physical trauma	
<input type="checkbox"/> 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	Was mom Strep B positive? Yes / No	
If yes, which ones? Epidural Episiotomy Forceps Suction	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		
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Birth injuries	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Congenital conditions: _____	
<input type="checkbox"/> Rash	<input type="checkbox"/> Colic	
<input type="checkbox"/> Infections	<input type="checkbox"/> Poor feeding	
<input type="checkbox"/> Respiratory distress	<input type="checkbox"/> 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 1 st 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?
