

## Child Health History form

Date \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ MSP# \_\_\_\_\_

Prov/State \_\_\_\_\_ Postal Code \_\_\_\_\_ Blood type \_\_\_\_\_

Parent/guardian's name \_\_\_\_\_ Phone(home) \_\_\_\_\_

Phone(work) \_\_\_\_\_ Email \_\_\_\_\_ Best time to call \_\_\_\_\_

Occupation \_\_\_\_\_ (full/ptime)

Other parent or guardian \_\_\_\_\_ Phone(home) \_\_\_\_\_

Emergency contact \_\_\_\_\_ relation? \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Please list below all other health professionals your child is currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, chiropractor, etc.)

\_\_\_\_\_  
\_\_\_\_\_

### Current Health Concerns:

What is your main reason for seeking naturopathic care for your child? If he/she has a specific health condition, please describe it in detail. When was the first time that you noticed the condition and describe any factors that you suspect may have played a role in its onset and its continuation.

How long has this been troubling your child? \_\_\_\_\_

Has it been getting (better, worse, remaining the same) and for how long? \_\_\_\_\_

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: \_\_\_\_\_

List all medications, supplements, herbs and homeopathic medicines your child is currently taking. Include dosage and results: \_\_\_\_\_

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

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

**Your Child's Health History:**

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

**PRENATAL HISTORY:**

What was the level of health of both parents at time of conception? (circle)

Mother:            poor    fair    good    excellent

Father:            poor    fair    good    excellent

What was the state of health of the mother during the pregnancy? Poor    Fair    Good    Excellent

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 (German measles)
Chlamydia	HIV	genital herpes	syphilis
strep infection	severe nausea	Hypertension	diabetes
hypothyroidism	hyperthyroidism	eclampsia	depression

Other: \_\_\_\_\_

List any supplements, medicines, herbal medicines and homeopathic medicines taken by the mother during pregnancy: \_\_\_\_\_

What was the mother's emotional state 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

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

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	Hypoglycemia	Epilepsy	Hyperthyroidism
Diabetes	Warts	Heart disease	Heart attack	
Canker sores	Hypertension	Hepatitis	Whooping cough	
Mononucleosis	Diabetes	Rubella	Diphtheria	

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

- 1.) \_\_\_\_\_ Date \_\_\_\_\_
- 2.) \_\_\_\_\_ Date \_\_\_\_\_
- 3.) \_\_\_\_\_ Date \_\_\_\_\_
- 4.) \_\_\_\_\_ Date \_\_\_\_\_

Is your child currently working with a professional counsellor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist? (yes / no) Have they in the past? (yes / no) If so, when?

\_\_\_\_\_

Previous surgeries and hospitalizations not mentioned above (include dates) \_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies to any drugs, herbs, foods, animals or other? (yes / no)

Please list: \_\_\_\_\_

## NUTRITION HISTORY

Was your child breast 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.

<b>Foods Introduced:</b>	<b>Age:</b>	<b>Reactions:</b>
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Describe your child's typical daily diet:

What is your child's favourite food? \_\_\_\_\_ Least favourite food? \_\_\_\_\_

How much water does your child drink a day? \_\_\_\_\_

Any problems with bowel movements? If so, describe: \_\_\_\_\_

**VACCINATIONS**

Please note next to each vaccination, when the shot was given and any reaction noticed:

MMR \_\_\_\_\_

DPT \_\_\_\_\_

Polio \_\_\_\_\_

Hemophilus influenza B \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Chicken pox \_\_\_\_\_

Other \_\_\_\_\_

**GROWTH AND DEVELOPMENT**

Note age, in months, when your child started to:

Roll over \_\_\_\_\_ Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

**GROWTH AND DEVELOPMENT con't**

When did their first tooth start coming in? \_\_\_\_\_ Any problems? \_\_\_\_\_

When was bladder control achieved? \_\_\_\_\_ Bowel control? \_\_\_\_\_

Has your child had problems with toilet training? (yes / no) Describe: \_\_\_\_\_

Does your child have any speech problems? (yes / no) \_\_\_\_\_

Does your child have any of the following habits? (circle)  
 bed rocking    head banging    thumb sucking    tics    breath holding    nail biting

**SLEEP**

Does your child have now or had in the past: (circle)  
 nightmares    insomnia    sleep walking    bed wetting    teeth grinding

**FAMILY HISTORY**

Please list ages, health problems and if deceased, cause of death:

	Living (age)?	Health problems	Died (age)?	Cause
<b>Mother</b>				
<b>Father</b>				
<b>Siblings</b>				
<b>Maternal:</b>				
<b>Grandfather</b>				
<b>Grandmother</b>				
<b>Paternal:</b>				
<b>Grandfather</b>				
<b>Grandmother</b>				

What is your child's ethnicity? \_\_\_\_\_

Does your child have any blood relative who suffers/or who has suffered from: (circle)

allergies	arthritis	asthma	cancer	diabetes
depression	eczema	heart disease	genetic disease	hypertension
ulcers	cataracts	thyroid disease	hypoglycemia	seizures
gonorrhea	tuberculosis	syphilis	schizophrenia	bipolar disorder
anemia	stroke	sickle cell	Alzheimer's	

**ENVIRONMENT**

Describe your child's current living arrangements: \_\_\_\_\_

What are your child's main interests and hobbies? \_\_\_\_\_

What does your child worry about? \_\_\_\_\_

How often does your child exercise per week? \_\_\_\_\_ What kind and for how long? \_\_\_\_\_

Does your child have dietary restrictions; religious or ethical? \_\_\_\_\_

What religion is your child? \_\_\_\_\_

Is your child in daycare? (yes / no) How many hours of TV does he/she watch per day? \_\_\_\_\_

How much time per day does your child spend playing video games or using the computer? \_\_\_\_\_

To your knowledge, has your child ever been physically or sexually abused? \_\_\_\_\_

How long has your child lived at his/her present address? \_\_\_\_\_

Where has she/he lived previously? \_\_\_\_\_

Is the home damp or moldy? (yes / no) How is your home heated? \_\_\_\_\_

Is your child exposed to second hand smoke? (yes / no)

What kind of drinking water does your child drink? (circle)  
bottled water   filtered water   distilled water   tap water

List any pets in the child's home: \_\_\_\_\_

Does your child have any problems at school? If so describe: \_\_\_\_\_

Please feel free to comment on any other concerns in the space below. Thank you for taking the time to fill out this form. The information is extremely useful for developing an effective treatment plan for your child.

*Return completed form to:*  
  
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