

CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Today's Date: _____

Child's Name: _____ Sex: M F

Birth Date (DMY) _____ Adopted Y N

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ BC CareCard Number: _____

Parent/Guardian/Caretaker:

Name 1) _____ Name 2) _____

Phone: _____ Work: _____ Phone: _____ Work: _____

Email: _____ Email: _____

Check ONE: Married Single Widowed Divorced Separated Common Law Same Sex

Emergency Contact: Name: _____ Phone: _____

Relationship to child: _____

Other Healthcare Providers

Medical Doctor: _____ Phone _____

Chiropractor: _____ Phone _____

Other: _____ Phone _____

Who referred you to Alta Vista Naturopathic Clinic? _____

CURRENT HEALTH CONDITION

What are your health concerns/problems that bring you in today? _____ Date Began? _____

_____	_____
_____	_____
_____	_____

Has anything recently changed or become worse? _____ When? _____

_____	_____
_____	_____

Current Medications: [prescription and OTC (ie Tylenol, Ibuprofen, laxatives)]

Medication/Dosage _____ For? _____ Since when? _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations, Surgeries, Injuries: [please list all procedures, complications and dates]

Year Surgery, Illness, Injury _____ Outcome _____

Laboratory procedures performed: [eg blood, urine, stool, allergy, skin scraping]

VACCINATION AND IMMUNIZATION HISTORY: [Please fill in the appropriate boxes]

<i>Vaccination</i>	<i>Age</i>	<i>Date of Immunization</i>	<i>Reaction or side effects</i>
Hep B			
HiB			
MMR			
Varicella (chicken pox)			
Smallpox			
DPT			
Flu			

Other Vaccinations: _____

DIET AND ELIMINATION:

Breastfed Y N [if current _____ number of times a day and length_____] **solids** Y N

Nutrition and Diet:

Mixed food diet [animal and vegetable sources] Vegetarian[type] _____
Vegan Calorie restricted Religious restrictions

Specific food restrictions:

Dairy Wheat Eggs Soy Corn Gluten
Other _____

Please List Any food allergies that you know you have: _____

Eating Habits

Skip breakfast One meal/day Two meals/day Three meals/day
Graze [small frequent meals] Snacks Eat constantly whether hungry or not
Eat only when hungry Generally eat on the run

Food Frequency

Servings per day:

Fruits[not including citrus] _____ Citrus Fruits _____ Dairy _____
 Dark green veggies _____ Deep coloured veggies _____ Beans/Peas/Legumes _____
 Eggs _____ Fish _____ Meat/Poultry _____ Grains[unprocessed] _____

Beverage Frequency

Water glasses/day _____ Juice glasses/day _____ Soda [uncaffeinated] _____
 Soda [caffeinated] cans/day _____ Other sources of caffeine: _____

Do You eat/use any of the following foods on a regular basis?

- Artificial sweeteners Candy Carbonated beverages Fast food
Fried foods Margarine Microwave Plastic wrap
Processed meat

Supplements You Are Taking:

- Multivitamin/mineral Vitamin C Vitamin E EPA/DHA
Calcium MagnesiumProbiotic Minerals _____
 Super green foods Amino acids Homeopathy Other _____

Elimination:

Bowel Movements: _____/day _____ colour __ blood __ diarrhea __ straining __ itching
 Urination: _____/day _____ colour __ pain __ itching __ blood __

Environment:

Are you exposed to tobacco smoke [work, home, etc.]? Y N
 Are you exposed to animals [work, home, etc.]? Y N

Sleep

How many hours of sleep per night? _____ What time do you go to sleep? _____
 Do you wake during the night? Y N If yes, number of times? _____
 Where do you sleep? _____ In what position? _____
 Do you take naps during the day? Y N Frequency: _____ Length of time? _____
 Any concerns with regards to sleeping? _____

Is there anything pertaining to this child that should not be mentioned in his/her presence?

FAMILY HISTORY
(parents and siblings)

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug addiction |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Genetic disorders |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis |

- High cholesterol
- Infertility
- Learning disabilities
- Migraine headaches
- Neurological disorders
 - Parkinson's
 - Paralysis
 - seizures
 - Other
- Thyroid disease

- High blood pressure
- Kidney disease
- Mental illness
- Obesity
- Stroke

- Venereal disease

- Hypoglycemia
- Kidney
- Mental retardation
- Osteoporosis
- Suicide

- Other _____

Please complete if child is under 2 years of age:

Prenatal Health History:

Mother (M) Father (F) [please write M or F where appropriate]

Height: M_____ F_____ Weight: M_____ F_____

Smoker? Y N M F _____Years _____amount/day _____year stopped

Alcohol? Y N M F Type_____ Frequency/Amount _____

Coffee? Y N M F _____cups/day

Soft drinks? Y N M F _____ cups/day

Artificial sweeteners? Y N M F _____teaspoon/day

Regular Exercise?Y N Type_____ Duration_____ Frequency_____

Did you take vitamins? Y N If yes, please list:_____

Post Partum Health of Mother

Birth experience: [please write any details pertaining to the birth of this child that you feel are important in his/her wellbeing.] _____

Delivery Information: Premature Post Due _____Days Midwife Home
 Hospital Induction Forceps Episiotomy C-section

Other: _____

Diet: Food Groups Avoided:_____

Dairy Products? Y N Breast fed? Y N How long?_____

PHYSICAL EXAMINATION [to be completed by Naturopathic physician]

As a Newborn: length _____ Weight _____ APGAR _____

Current

Head circumference if under 3yoa _____ Chest Circumference _____

HNTEE

Head ROM _____ Skin _____ Hair _____
Masses _____ Lymph _____ Thyroid _____

NS/TH Frenulum _____ Pharynx _____ Gums _____
Teeth _____ Tonsils _____ Mucosa _____

Eye Nystagmus Y N L R Strabismus Y N L R Pupil size _____ mm

Ear TM _____ COL _____ Hearing _____

Lungs Perc _____ Auscultation _____

Circ Pulse Femoral L ____ R ____ Brachial L ____ R ____

M/S Scoliosis Y N _____ Posture _____

Muscle tone Good Fair Poor Spastic _____ Flaccid _____

ROM Hips: Ortolani +ve -ve

Barlow's +ve -ve

Gait: Genu Valgum Genu Varum

Coordination: _____

Reflexes Babinski +ve -ve Abdonminal +ve -ve

Anal +ve -ve

CN abnormalities: _____

Abdomen Hernia with straining Y N Bowel Movements _____

Liver _____ Kidney _____ Umbilicus _____

Mass _____ Lymph _____

Genitalia Discharge _____ Urination _____ Rash _____

testicular descent Y N