Integra Naturopathics

205, 908-17th Ave SW p: 403.284.2055 e: info@integranaturopathics.com

Child Health Questionnaire

Welcome to Integra Naturopathics. We know that your child's health is influenced by many factors. Your questionnaire provides valuable information which helps us to understand the underlying causes of your child's health concerns.

GENERAL CONTACT INFORMATION

Child's Name: _____
(last name) (first name) (middle initial)

Age: _____ **Gender:** ☐ Female ☐ Male **Date of Birth** (M/D/Y): _____/_____/_____

Address: _____
(street address) *(city)* *(province)* *(postal code)*

Parent/Guardian Name: _____

Telephone: Home _____ **Work** _____ **Cell** _____

May we leave messages on your phone line? ____ **Preference (circle all applicable):** Home/ Work/ Cell

Email: _____

How did you hear about this clinic? _____

Emergency Contact: _____
(name) (relationship) (telephone)

Primary physician? _____ **Last physical exam?** _____
(name) (telephone) (month) (year)

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are your child's main health concerns? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking, the dosage and the reason for using them:

1) _____
2) _____

Is your child hypersensitive or allergic to any of the following (please list):
Drugs? _____
Foods? _____
Environmental? (e.g. pollen, dust, perfume) _____
_____

MEDICAL HISTORY

List all surgeries your child may have had:
_____ year? _____ purpose? _____
_____ year? _____ purpose? _____
_____ year? _____ purpose? _____

Environmental Toxic Exposure
Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at home or travelling? **Y** **N**
Does your child live near power lines or a refinery? **Y** **N**
Does your child have mercury dental fillings? **Y** **N**
Does your child have any surgical implants (medical) **Y** **N**
Does your child have any body piercings? **Y** **N**
Has your child ever had any organ transplants? **Y** **N**
Has there been an event or sickness that your child has never fully recovered from? Please indicate below

_____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Cravings: _____
Aversions: _____

Does your child add salt to food? ☐ Yes ☐ No
Does you child drink pop, how much? _____
Does your child have any dietary restrictions? _____

GENERAL

Weight _____ Height _____

Does your child suffer from allergies? If yes, please explain: _____
Has your child had any specific allergy testing? If yes, please explain: _____
Roughly how many times has your child been on antibiotics? _____
Has your child been vaccinated? _____ Has your child experienced any abnormal reactions to the vaccinations? _____

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Diabetes	_____	Cancer	_____
Multiple Sclerosis	_____	Osteoporosis	_____
Arthritis	_____	Asthma	_____
Parkinson's	_____	Thyroid Condition	_____
Alzheimer's	_____	Eczema	_____
Heart Disease	_____	Mental Illness	_____
Other	_____		

SYMPTOM CHECKLIST

Please take a moment to circle the following symptoms and childhood illnesses which your child may have experienced either in the past, or presently.

Symptom Checklist

Appetite change
Bad Breath
Bed wetting
Burning Urination
Constipation
Cough
Cries Easily
Diarrhea
Dizziness
Easy Bruising
Eczema
Fatigue
Hair loss
Hearing loss
Indigestion
Insomnia
Nervousness
Nights Sweats
Sore Throat
Stomach Aches
Urinary Frequency
Visual Disturbances
Vomiting
Wheezing
Other: _____

Childhood Illnesses

Measles
Chicken Pox
Rubella
Mumps
Pneumonia
Tonsillitis
Recurrent Ear Infections
Frequent Colds
Allergies
Fevers
Impetigo
Rheumatic Fever
Scarlet Fever
Anemia
Sinusitis
Acute epiglottitis
Whooping cough
Mononucleosis
Asthma
Other: _____

HEALTH HISTORY FROM BIRTH

Birth mother's illnesses during pregnancy (circle):

Hypertension	Gestational Diabetes	Pre-eclampsia
Bleeding	Excessive Vomiting	Anemia
Trauma	Other: _____	

Substances used during pregnancy by birth mother (circle):

Tobacco	Alcohol	Caffeine
Mediations	Other: _____	

Type of labour (circle)	spontaneous	induced
Type of delivery (circle)	vaginal	C-section

Complications after delivery (circle):

Jaundice	Rash	Colic	Seizures
Respiratory Distress	Birth Defects	Bleeding	Fever
Other: _____			

Breast Fed: Yes No How long: _____
Bottle Fed: Yes No How Long: _____
Introduction of Solid Foods: When? _____
First Foods in order of introduction (specify if bottled or fresh)

_____

_____

Where there any reactions to the foods listed above? (colic, constipation, congestion etc)

_____

LIFESTYLE PATTERNS

Does your child sleep well?	**Y**	**N**	Does your child wet the bed?	**Y**	**N**
Does your child go to daycare?	**Y**	**N**	Does your child crave junk food?	**Y**	**N**

DEVELOPMENTAL MILESTONES

At what age did your child:

Crawl _____ Walk _____ Talk _____ Toilet train _____

Thank you for taking the time to fill out this form. We look forward to seeing you soon.