Child
Nutritional History

Date: _____

Child's Name: _____ Male
First Middle Last Female

Birthdate: _____ Alberta Health Care #: _____

Home Address: _____
Street City Province Postal Code

Home Phone: _____ Cell Phone: _____

Business Phone: _____ Email Address:_____

Mother and / or Father's name: _____Occupation:_____

Number and age of siblings: Brothers: #_____Ages:_____Sisters: #____Ages:_____

PAYMENT IS DUE AT TIME OF VISIT

Name of person responsible for payment: _____

Who may we thank for the referral? _____

Present MD: _____ Date and reason of last visit _____

Has your child previously seen a naturopath? _____If so, who?_____

Date and reason for last:_____

Describe your child's main health concern: _____

How long has your child had this condition? _____

History of mother's pregnancy

During the pregnancy did the mother: (please circle yes or no, please fill out as best you can remember. If you have forgotten certain details, place a question mark (?))

YES NO Have any traumas (falls, accidents, etc.)? Explain:_____

YES NO Have any illnesses? Please list:_____

YES NO Have any invasive procedures (amniocentesis, CV's)?_____

YES NO Have any exposure to ultrasound? How many:____ Medical reason?_____

YES NO Smoke? How often:_____

YES NO Drink alcohol? How often:_____

Where was the baby born? *hospital home midwife:* _____

Birth weight: _____ Birth length: _____ Duration of birth: _____

YES *NO* Was labor induced? Duration of gestation:_____

YES *NO* Was it a vaginal birth? *forceps* *vacuum extraction*

YES *NO* Were medications delivered to mother during birth?

If yes, please list:_____

After delivery:

YES *NO* Was there any difficulty with mother's lactation? Explain: _____

YES *NO* Was there any evidence of birth trauma? *bruising* *odd shaped head*

respiratory depression *cord around neck* *other:* _____

YES *NO* Was the child breast fed? How long:_____ Formula introduced at age:_____

Type of formula used: _____

YES *NO* Were there any smokers in the home? How much did they smoke:_____

YES *NO* Were there pets at home? Type:_____

YES *NO* Any vaccinations? Which ones and any reactions:_____

YES *NO* Were there any behavioral problems? Explain:_____

YES *NO* Did the child's sleeping patterns seem normal to you? Explain:_____

YES *NO* Were there any major falls from couches, beds, change tables, etc?

_____

Detailed Baby History (from birth to age 1)

YES *NO* Did your child have a preferred sleeping position? _____

YES *NO* Did your child have any feeding difficulties? _____

YES *NO* Did your child have a one sided breast-feeding preference? *left* *right*

YES *NO* Did your child frequently spit-up after feeding? _____

YES *NO* Did your child have difficulty burping? _____

YES *NO* Did your child cry a lot? How many hours per day? _____

YES *NO* Did your child pass a lot of intestinal gas? _____

YES *NO* Did your child have a preferred head position? _____

YES *NO* Did your child frequently arch his / her head or neck backwards?_____

YES *NO* Did your child have any major rashes or areas of dry skin?_____

YES *NO* Had your child ever had a fever? _____

YES *NO* Had your child had any other trauma? _____

List all nutritional supplements your child is taking. Include the brand, amount, why they are taking them, and how long they have been taking them. We ask that you bring all bottles to your consultation. *(If you need additional space please attach a sheet or use back of form)*

Supplement	Company	Amount	Reason for taking	How long

List all drugs (prescription or not) that your child is taking. Include the reason for taking, amount, length of time taken, and results. List all other drugs they have taken in the past.

Name	Amount	Reason for taking	How long	Results

List all surgeries your child has had, include the date, reason and results.

Surgery	Date	Reason	Results

List all allergies your child has to food, drugs, or other substances, along with the symptoms they produce and indicate how long they have suffered from each.

Allergy	Symptoms	How long

Give percentage for each of the following 3 questions (*total for each question should be 100%)*

- Where daily diet is prepared: ____ *home* ____ *restaurant*
  ____ *fast food* ____ *vending machine*
- How food is prepared: ____ *baked* ____*broiled* ____*boiled* ____ *fried*
  ____ *steamed* ____ *microwaved* ____ *grilled* ____*raw*
- Food prepared from: ____ *fresh* ____ *canned* ____ *frozen* ____ *prepackaged*

Circle all that apply:

- Child's appetite is: *normal excessive poor none*
- Child craves: *sweets salt chocolate water dirt other*: _____
- Water used for drinking/cooking: *tap/city spring well rain distilled*
  filtered reverse osmosis
- If purchased water, is it in: *soft plastic hard plastic glass*
- Foods that disagree with the mother: *raw vegetables raw fruit fats fried beans*
  sugar milk/dairy greasy eggs onions cabbage highly spiced
  *other:*_____
- What symptoms does the child get from foods that disagree with them?
  _____
- Has the child ever done a detoxification program? *Yes No*
  Details:_____
- What is the child's current weight and height? _____
- Has your child had any abnormal weight changes? _____
- Exercise*: days per week:* ____ *minutes per day:*____*Type:*_____

Bowel Health (BM = Bowel movement or stool)

- How often does the child have a BM? ___*times / day* ___*times / week*
- Do they use laxatives? *Yes No* How often*?* _____

Answer key for the following: 0=never 1= rarely 2= frequently 3= always

Stool size
__thin, long or narrow
__large, hard
__difficult to pass

Stool consistency
__loose but not watery
__diarrhea
__alternating hard / diarrhea

Stool color
__med/dark brown
__very dark / black
__yellow/tan/clay
__greenish
__blood is visible
__mucous in / around

- Any cuts/bleeding around anus? *Yes No* _____

Urinary Tract Health

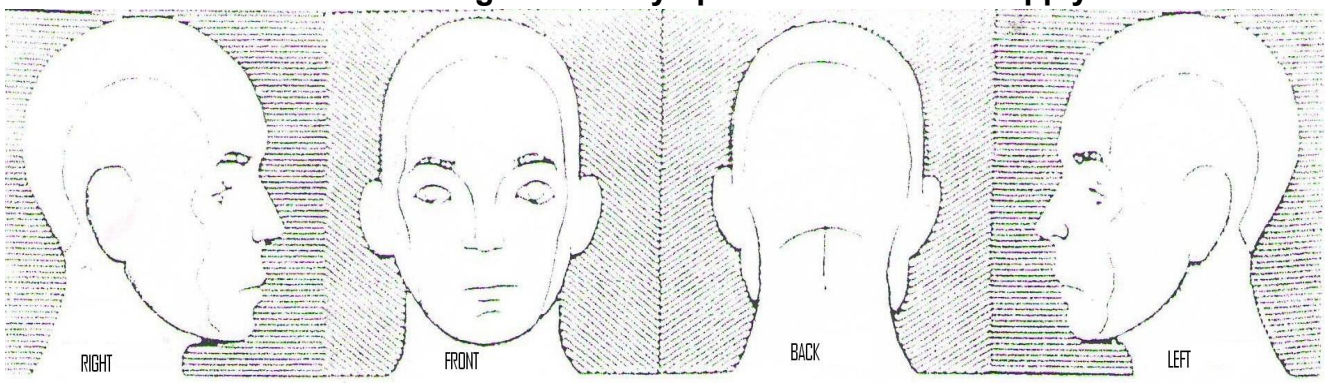
- My child urinates: ___*times per day* ___ *times per night*
- Urination is: *more frequently than normal* *with pain* *with itching or burning*
- My child's urine color is: *pale yellow* *bright yellow* *dark yellow* *other* _____
  clear *cloudy* *with mucous* *varies a lot*
- My child's urine has: *no odor* *odor* *describe:*_____

Digestion

- Does the child have discomfort: *immediately after eating* *1-2 hours after eating*
  3-5 hours after eating
- When the child passes gas is there: *no odor* *some odor* *odor usually* *foul smelling*

Head, Mouth and Throat

Mark areas of rashes or bruising or other symptoms. Mark all that apply.



- The child's tongue is: *covered with small taste buds* *coated*_____*color* *shiny spots*
- The child's tongue color is: *pink* *red* *red and blotchy* *pink with red tip*
- The child's tonsils are: *normal* *removed at age* ___ *enlarged* *spotted*
- The child's lips are: *normal* *dry* *peel a lot* *fever blisters often* *cracked corners*
- Does your child have headaches: *daily* *weekly* *rarely* *never* *wake up with*
  a.m. *p.m.*

Muscle, Joint, Ligament and Nerve *circle all that apply:*

- Does your child indicate pain in: *neck* *mid-back* *low back* *hip* *knee* *ankle*
  feet *shoulder* *elbow* *wrist* *hands* *other*_____
- Does your child get: *swollen joints* *joints pop or "crack"* *muscle spasms*

Hair, Skin and Nails *circle all that apply:*

- Hair: *normal course fine oily dry*
- Finger / toe nails: *normal brittle / break easily soft ridged vertically white spots grow fast ridged horizontally grow slow shaped oddly hangnails*
- Skin: *normal oily dry flaky acne psoriasis boils*
- Spots on skin: *warts moles small red large red brown white*
- Dry cracked or bleeding areas on: *hands heels feet other :*_____

Chest and Heart *circle all that apply:*

- Does your child indicate any chest pain: *with touch with coughing with position with activity*
- Does the child's pulse / heartbeat seem : *too fast too slow skips beats*

Respiratory, Lungs and Allergies

- Does your child have nasal congestion: *daily several times per week only occasionally*
- Is the child's mucous: *clear yellow green blood tinged other:* _____
- Does your child have: *hoarseness hay fever asthma wheezing snoring non-productive cough (without mucous) productive cough (with mucous)*
- Does your child have / had: *frequent colds/flu pneumonia sinus infections antibiotics (how many times:*_____ *)*

Continued on next page.....

Please fill out your family health history on the chart below.
Put an “N” in the box if your child has it now, or a “P” if they have had it in the past.

	Alcoholism	Allergies	Alzheimer's	Arthritis	Asthma	Atherosclerosis	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	High blood pressure	Kidney Disease	Obesity	Osteoporosis	Sinus Problems	Stroke	Throid Problems	Tuberculosis	Ulcers
Child																				
Mother																				
Father																				
Sisters																				
Brothers																				
Maternal Grandparents																				
Paternal Grandparents																				

Use this space to add anything else you would like to share about your child's health concerns that you think the doctor should know:

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your child's health goals.

Signature_____Date_____