CHILD (Infant to 5 years) NATUROPATHIC INTAKE

General Naturopathic Medicine Practice of
Dr. Hayley Owens ND

Name: _____ Today's Date: _____

DOB (m/d/y): _____ Age: _____

Parent(s) or Gaurdian(s): _____

_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____

Phone Number: Home: _____ Cell: _____

Work: _____

Medical Doctor: _____

Name of Clinic: _____Phone Number: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

GENERAL

Height:	Weight:
When during the day is your child most energetic?	Worst:
Exercise: Yes / NO	If so what kind and how often:
Watch TV: Yes / NO	How many hours per day?
Does your child have any contagious illness at this time? Yes / NO	If yes what?

MEDICATIONS

Please list any prescription, over the counter medications, vitamins or other supplements you are taking (including dose, brand name and how long)

Please list any past prescription medications:

CURRENT HEALTH CONCERNS

Please list your child's health concerns in the order you feel is the most important

MEDICAL HISTORY

___ Chicken pox ___Scarlet fever ____ Roseola _____ Measles

___ Measles ___ Pneumonia ____ Strep throat _____ Mumps

___ Whooping cough ____ Ear infections ____ Diphtheria ____ Rubella

___ Rheumatic fever ____ German measles

IMMUNIZATIONS (check all that apply)

____ MMR ____ Smallpox ____ Polio _____ DPT _____ H. Influenza B

_____ Influenza _____ Hepatitis A _____ Hepatitis B

Please list other vaccines

Any adverse reactions to vaccines: _____ Yes _____ No

If yes please describe:

BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at birth of child:

Mother's health during pregnancy (please explain)

Were any of the following experienced during pregnancy? (check all that apply)

____ Bleeding ____ Nausea/Vomiting ____ Illness ____ Cigarette smoking

____ Alcohol consumption ____ Drug use ____ Medication ____High blood pressure

____ Thyroid problems ____ Gestational diabetes ____ Anemia ____ Mental Illness

____ Yeast infections ____ Digestive disease ____ Anxiety ____ Asthma

____ Eczema/Psoriasis ____ High stress

CHILD'S BIRTH HISTORY

TERM:

____ Full ____ Premature _____ weeks ____ Late _____ weeks

Birth and Labor

____ Vaginal ____ C – Section _____ Induced _____ Forceps

_____Anesthesia

Weight at birth _____ Length of labour _____

Please list any problems after birth

FEEDING

_____ Breastfed? How long? _____

_____ Formula? If yes, what type/brand:

Child's sleep patterns (please explain)

How would you describe your child's temperament?

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?

Any foods?
Any environmental or chemical allergies?

DIET

Any dietary restrictions (religious, vegetarian, vegan etc)

If applicable, please indicate what age your child began solid food

Please specify which foods

DEVELOPMENTAL MILESTONES

If applicable, please indicate what age your child began:

Sitting _____ Crawling _____ Walking _____

Talking _____