KAMLOOPS NATUROPATHIC CLINIC ltd.
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HEALTH HISTORY QUESTIONNAIRE – PEDIATRIC NEWWWW

Date: _____

(All information is held absolutely CONFIDENTIAL)

Name: _____ P.H.N: _____
(Care Card Number)

Birth Date: _____ Age: _____ M or F (Circle Please)

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Email address:_____ Occupation: _____

Emergency Contact Information:

Name: _____ Relationship to you: _____

Contact Numbers: _____

Names of other Healthcare Providers: _____

Are you currently under the care of another Physician? _____

Are you currently taking any medications? Please list: _____

_____

Are you currently on any supplements or remedies? Please list: _____

_____

How did you hear about our clinic? _____

What are your main concerns today and when did they begin?

_____

_____

Have they been diagnosed? _____

Have there been any improvements made? _____

Past/Recent Surgeries? _____

Past/Recent Trauma (Physical and emotional)?

_____

Does your child have any allergies (to medications, pollen, animals or food)?

_____

_____

Please indicate any other problems you would like to discuss: _____

_____

Past Medical History

If your child has any of the following conditions below, please check the appropriate box – **P**ast or **C**urrent.

Condition	P	C	Condition	P	C	Condition	P	C	Condition	P	C
Acne			Dizzy Spells			Malaria			Tonsilitis		
Allergies			Earaches/Infections			Mononucleosis					
Anemia			Exposure to cigarette smoke			Moodiness			Tuberculosis		
Bed wetting			Epilepsy/seizures			Mumps			Typhoid Fever		
Birth defects			Fatigue			Parasites			Vomiting spells		
Cancer			Frequent Colds and Flu			Pneumonia			Warts		
Chicken Pox			Headache			Rheumatic Fever			Whooping Cough		
Colic			Heart murmur			Rubella			Worms		
Cold Sores			High Fever			Scarlet Fever					
Constipation			Hyperactivity			Skin Disease					
Cough/wheezing			Insomnia			Sinusitis					
Cradle Cap			Jaundice			Strep Throat					
Depression			Learning Disorder			Stuffy nose					
Diarrhea			Low/High BP			Thrush					

Surgeries (year & type)	Hospitalizations (year & reason)	Injuries/Accidents (year & cause)

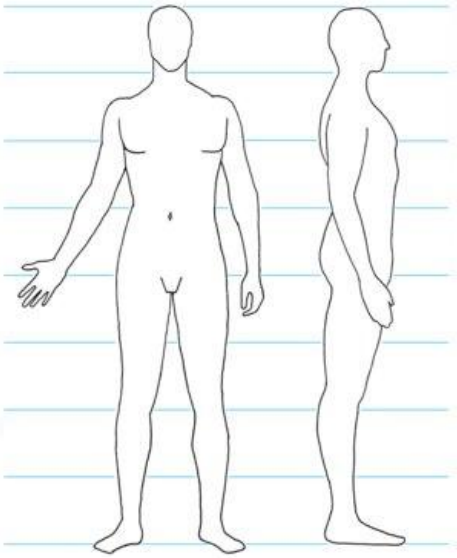
Immunization	Age give	Any Adverse Reactions?
DPT (Diptheria, Pertussis, Tetanus)		
MMR (Measles, Mumps, Rubella)		
Polio		
Haemophilus Influenza Type B (Meninitits)		
Hep-B (Hepatitis B)		

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

Physical Exam		**HIV test**	
Pap Smear		**Chest X-ray**	
Prostate Exam		**EKG**	
Mammogram		**STD Screen**	
Colonoscopy		**Cholesterol test**	
TB test		**Blood glucose**	
Bone density test		**Urinalysis**	
Other physical exam		**Fecal Occult Blood**	
Other imaging test		**Other test**	

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Family Medical History

Has any family member had:	Yes	Which Relative & Age of Onset	Doctor's Notes
Diabetes			
Severe allergies			
Stroke			
Heart Disease			
Heart attack			
Blood Clots in Legs or Lungs			
High Blood Pressure			
High Cholesterol			
Kidney disease			
Osteoporosis			
Hepatitis			
Thyroid Problems			
Colitis/Crohn's Disease			
Tuberculosis			
Birth Defects			
Alcohol or Drug Addiction			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Other Cancer			
Mental Illness/Depression			
Alzheimer's Disease			
Other:			

Lifestyle and Social History

Parents:	Married Separated Divorced	**Doctor's Notes**
Mother's occupation:	Full time: Part time	
Father's occupation:	Full time: Part time	
Other guardian (s):	Relationship	
Number of Siblings		
Daycare, Preschool, School	Hrs per day: Hrs per week:	
Regular Exercise	Type:	

Social	**Yes**	**No**	**Details**	**Doctor's Notes**
Interacts well with others?				
Good support network of family and friends?			Who?	
What is the child's predominant emotion?				

Lifestyle
Stress Level (please circle): Low Medium High
Stress Source:
What does the child do to relieve stress?
Please rate your energy level on a scale from 1-10 (10 = highest energy)

Sleep	**Yes**	**No**	**Details**	**Doctor's Notes**
Problems falling asleep				
Problems staying asleep				
Regular bedtime?			Typical bedtime?	
Regular wake up time?			Typical wake up time?	
Wake rested in the morning?			Average hours of sleep per night?	
Dreams?				

Diet	**Doctor's Notes**
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your child's typical breakfast?	
What is your child's typical lunch?	
What is your child's typical dinner?	
Snacks? Desserts/Treats?	
How many glasses of water consumed per day?	
What other fluids does your child drink and how much per day?	
What is your child's current weight?	
What was your child's weight one year ago?	

Prenatal/Birth Feeding/Feeding History:

Mother's Health During the Pregnancy with this Patient	Doctor's Notes
_____Age _____Alcohol consumption _____Smoking _____Bleeding _____Stress _____X-rays _____Nausea _____Drugs _____Medications _____Trauma/Injury _____High Blood Pressure _____Other:	
Term: ___Premature ___Full ____ Birth weight	
Was Pregnancy/Birth: ___Easy ___Difficult ____C-section	
Feeding of infant: ___Breast fed – how long? _____ ___Formula fed – how long? _____ Type of Formula _____ Age solids began? _____ Any cow's milk? _____	