



Please list any past / current prescription medications, over the counter medications, vitamins, herbs, homeopathics or other supplements your child has / is taking, the dosage and how effective you have found these treatments:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

Approximately how many times has your child been treated with antibiotics? \_\_\_\_\_

Is your child hypersensitive or allergic to any of the following (please list):

Drugs? \_\_\_\_\_

Foods? \_\_\_\_\_

Environmental? (e.g. pollen, dust, perfume) \_\_\_\_\_

\_\_\_\_\_

Please describe what type of reaction your child experiences with an allergy attack?

\_\_\_\_\_

\_\_\_\_\_

Has your child had any specific allergy testing? If yes, please explain: \_\_\_\_\_

Does your child have a medic alert? \_\_\_\_\_

### **MEDICAL HISTORY**

List all surgeries your child has had:

\_\_\_\_\_ year? \_\_\_\_\_ purpose? \_\_\_\_\_

\_\_\_\_\_ year? \_\_\_\_\_ purpose? \_\_\_\_\_

\_\_\_\_\_ year? \_\_\_\_\_ purpose? \_\_\_\_\_

Are there any traumatic events (surgeries, drug reactions, serious illness, accidents etc.) that you feel may have caused or contributed to your child's health problems?

\_\_\_\_\_

Has your child ever been to the emergency room? If so, what was it for? \_\_\_\_\_

\_\_\_\_\_

### Environmental Toxic Exposure

Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium etc) while at work, home or travelling?      Y      N

Does your child live near power lines or a refinery?      Y      N

Is your child's home and school environments well-ventilated?      Y      N

Is your child exposed to significant tobacco smoke (home, etc.)?      Y      N

Is your child frequently exposed to animals (pets, etc.)?      Y      N

Does your child have mercury dental fillings?      Y      N

Does your child have any surgical implants (medical, cosmetic)      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

Please check all vaccinations your child has had:

DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/>	Hib (Haemophilus influenza B)	<input type="checkbox"/>
D-PTP (diphtheria, pertussis, tetanus, polio)	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>
MMR (measles, mumps, rubella)	<input type="checkbox"/>	Smallpox	<input type="checkbox"/>
OPV (Polio)	<input type="checkbox"/>	Td + P (tetanus, diphtheria, polio)	<input type="checkbox"/>
Flu	<input type="checkbox"/>	Other	<input type="checkbox"/>

Has your child experienced reactions to their vaccinations? Please explain:

\_\_\_\_\_

\_\_\_\_\_

Has a sibling of the child experienced an adverse reaction to any of their vaccinations? Please explain:

\_\_\_\_\_

\_\_\_\_\_

### TYPICAL FOOD INTAKE

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

Cravings: \_\_\_\_\_

Aversions: \_\_\_\_\_

Do you add **salt** to your child's food?       Yes       No

How many **cups / day** does your child drink of the following?

Pop \_\_\_ Fruit juice \_\_\_ Herbal tea \_\_\_ Cow's Milk \_\_\_\_\_

How many glasses of **water** does your child drink per day?

Tap \_\_\_ Filtered \_\_\_ Distilled \_\_\_ Reverse Osmosis \_\_\_ Spring \_\_\_

What temperature of liquid does your child prefer to drink? (circle)      hot      cold      room temp.

Does your child have any dietary restrictions (religious, vegetarian, vegan etc.)?

\_\_\_\_\_

Are you satisfied with your child's diet the way that it is now? Why or why not?

\_\_\_\_\_

\_\_\_\_\_

**GENERAL**

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_

**FAMILY HISTORY**

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

Allergies	_____	Eczema	_____
Anemia	_____	Heart Disease	_____
Asthma	_____	Juvenile Arthritis	_____
Autoimmune disease	_____	Kidney Disease	_____
Birth defects	_____	Mental illness	_____
Bleeding disorder	_____	Seizure/Epilepsy	_____
Cancer	_____	Stroke/Aneurysm	_____
Crohn's or colitis	_____	Thyroid condition	_____
Diabetes	_____	Tuberculosis	_____
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**

	<b>Past</b>	<b>Now</b>
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bleeding nose	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chronic runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Colic / gas / cramping	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Cradle cap	<input type="checkbox"/>	<input type="checkbox"/>
Cries easily	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Diaper rash	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Hives	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____	

**Childhood Illnesses**

	<b>Past</b>	<b>Now</b>
Acute epiglottitis	<input type="checkbox"/>	<input type="checkbox"/>
ADHD / ADD	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis (pink eye)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Head lice	<input type="checkbox"/>	<input type="checkbox"/>
Impetigo	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis / Strep throat	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____	

**Bowel Habits**

Frequency of stool \_\_\_\_\_ times per day \_\_\_\_\_ times per week \_\_\_\_\_

**HEALTH HISTORY FROM BIRTH****Health of parents**

<b>Inquiry</b>	<b>Excellent</b>	<b>Good</b>	<b>Fair</b>	<b>Poor</b>	<b>Unknown</b>
Health of mother at time of conception					
Health of father at time of conception					
Health of mother during pregnancy					
Emotional state of mother during pregnancy					
Mother's diet during pregnancy					

**Birth mother's illnesses during pregnancy (circle):**

Hypertension	Gestational Diabetes	Pre-eclampsia	Eclampsia
Bleeding	Excessive Vomiting / Nausea	Anemia	Placenta previa
Trauma	Maternal rubella	Maternal toxoplasmosis	Cold / Flu
Other: _____			

**Substances used during pregnancy by birth mother (circle):**

Tobacco	Alcohol	Caffeine	Recreational drugs
Prescription Medications	Herbal Preparations	Over the counter drugs	
Other: _____			

**Interventions used during the pregnancy (circle):** Ultrasound                      Amniocentesis**Term length of pregnancy (circle):**

Pre-term (37 weeks or less)              Full term (38-42 weeks)                      Post term (42 weeks)

**Type of labour (circle) :**              Spontaneous              Induced**Type of delivery (circle):**              Vaginal              C-section**Where did the birth take place?**      Hospital              Home              Other**Interventions used during the delivery (circle)**      Epidural              Forceps              Suction**Complications with the delivery (circle):**Difficult delivery      Long 2<sup>nd</sup> stage of labour      Breech delivery      Shoulder dystocia              Other \_\_\_\_\_**Interventions administered at birth (circle):**              Vitamin K              Eye drops**At birth:** Weight \_\_\_\_\_ Length \_\_\_\_\_      APGAR Scores \_\_\_\_\_**Complications after delivery (circle):**

Jaundice	Rash	Colic	Seizures
Respiratory distress	Birth defects	Bleeding	Fever
Hip displacement	Scoliosis	Injuries during birth	Infections
Other: _____			

Breast Fed:      Yes      No                      How long: \_\_\_\_\_

Bottle Fed:      Yes      No                      How Long: \_\_\_\_\_

What type of formula was used? (milk, soy, other) \_\_\_\_\_ Combined with breast milk? \_\_\_\_\_

Were there any reactions to the formula? \_\_\_\_\_

Introduction of Solid Foods:                      When? \_\_\_\_\_

First Foods in order of introduction (specify if bottled or fresh)

---



---

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

---

### DEVELOPMENTAL MILESTONES

At what age did your child:

Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_ Toilet train \_\_\_\_\_

### LIFESTYLE PATTERNS

What time does your child go to bed? \_\_\_\_\_ Wake ? \_\_\_\_\_

Does your child take naps? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

Does your child have trouble falling asleep? \_\_\_\_\_

Does your child sleep through the night? \_\_\_\_\_

What position does your child sleep in? \_\_\_\_\_

Does your child wake up looking / acting refreshed? \_\_\_\_\_

Does your child have any recurring dreams or nightmares? \_\_\_\_\_

What is your child's energy like during the day? \_\_\_\_\_

Is your child currently in school, daycare, at home? \_\_\_\_\_

How would you describe your child's behaviour in school / daycare \_\_\_\_\_

Does this differ greatly from behaviour at home? \_\_\_\_\_

Does your child watch TV? Yes No How often? \_\_\_\_\_

Does your child play video games? Yes No How often? \_\_\_\_\_

Does your child play on the internet? Yes No How often? \_\_\_\_\_

Does your child have family time? Yes No How often? \_\_\_\_\_

Does your child get exercise? Yes No How often? \_\_\_\_\_

What does your child like to do for exercise? \_\_\_\_\_

What are your child's hobbies / interests? \_\_\_\_\_

Please write a short description of your child as he/she is currently. Include strengths, weaknesses, fears and major personality traits:

---



---



---



---

Is there anything that you feel is important that has not been covered? \_\_\_\_\_

---



---

Thank you for taking the time to fill out these forms.