Head to Heal Family Wellness

Centre for Naturopathic Medicine & The Bowen Technique

CHILDREN'S QUESTIONNAIRE

(To be completed by parent/guardian)

Date: _____

Child's Name: _____ Mother's/Guardian's Name: _____

Mother's/Guardian's Occupation: _____

Address: _____ Work Phone Number: _____

_____ Father's Name: _____

Father's Occupation: _____

Work Phone Number: _____

Home Phone Number: _____

Child's Birth date: _____ Child's Age: _____

How did you hear of ***Head to Heal***? _____

Name of your child's pediatrician/doctor: _____

Does this child see any other health care providers? No Yes If yes please provide details _____

_____

Please state your child's primary reason for attending this clinic. Please list the first time you noticed the condition and describe any factors that you suspect may have a role in its onset and perpetuation:_____

_____

_____

Please list any other health concerns/complaints: _____

_____

_____

PAST MEDICAL HISTORY:

Childhood Illnesses (***please check and indicate child's age at time of infection***)

- ○ Measles _____
- ○ Rubella _____
- ○ Mumps _____
- ○ Whooping Cough _____
- ○ Chicken Pox _____
- ○ Pneumonia _____
- ○ Rheumatic fever _____
- ○ Scarlett fever _____
- ○ Polio _____
- ○ Tonsillitis _____
- ○ Frequent colds
- ○ Ear infections (how many?_____)
- ○ Mononucleosis _____
- ○ Strep throat _____
- ○ Conjunctivitis _____
- ○ Other _____

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2706 13th Avenue
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VACCINATION RECEIVED: (***please check or attach a photocopy of vaccination record***):

Type of vaccination	**Date received?**	**Type of vaccination**	**Date received?**
○ Diptheria, Pertussis, Tetanus		○ Measles, Mumps, Rubella	
○ Polio		○ Chicken pox	
○ Haemophilus Influenza B		○ Prevnar	
○ Influenza		○ Other	

Please note any adverse reaction to vaccinations (For example: redness at site, crying, screaming, fever, limp etc.) _____

_____

FAMILY HISTORY: (***please indicate where applicable***)
Was this child adopted? No Yes, If yes please indicate date: _____

	Father	**Mother**	**Brothers**	**Sisters**	**Grandmother**		**Grandfather**	
					Maternal	**Paternal**	**Maternal**	**Paternal**
Age (if living)								
Health (**G**=good, **P**=poor)								
Allergies								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilespy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								

Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

List all family members the child lives with: _____

PRENATAL HISTORY:

Parents health at conception (**G**= good, **P**= poor): Mother _____ Father: _____
Was the child conceived naturally? Yes No

Any fertility interventions? Yes No

Any illness of difficulties during pregnancy for mother? (***please circle***)

Nausea	Diabetes	Hypertension	Thyroid problems	Emotional Trauma	Vomiting
Bleeding	Illness	Physical trauma	Any other: _____		

List all drugs, alcohol, cigarette smoking or medications taken during pregnancy:

_____

_____

List any vitamins or other supplements taken during pregnancy: _____

_____

Mother's age at birth: _____ Father's age at conception: _____
Mother's pregnancy weight gain _____ lbs

BIRTH HISTORY:
How long was the pregnancy? (***please circle***) Full Term Late Premature _____ # of weeks
Was the labour spontaneous or induced? (***please circle one***)
Duration of labour?: _____ hrs
Difficulties or complications:

_____

_____

Was the delivery by C-section or vaginal birth? (***please circle one***)
Hospital or Home Birth (***please circle one***)

Child's Birth Weight? _____ Child's Birth length: _____ APGAR scores: 1 min _____

5 min _____

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Interventions: (***please circle***) Epidural Episiotomy Forceps Suction
Complications:

_____

_____

NEONATAL HISTORY:
Any difficulties or complications soon after birth? (***please check where applicable***)

- ○ Jaundice
- ○ Respiratory distress
- ○ Convulsions
- ○ Birth defects
- ○ Rashes
- ○ Poor feeding
- ○ Anemia
- ○ Infections
- ○ Colic
- ○ Other

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____ 1st tooth _____
Any problems with the child's teeth? _____
How would you characterize your child's development? (circle)

Physical:	Slow	Average	Fast
Mental:	Slow	Average	Fast

Has child started puberty? No Yes, If yes when? _____

NUTRITION:
Infant feeding: Breast fed – how long? _____
Formula fed – describe type: _____
When started: _____
Age of introduction of solids: _____
What were the first foods introduced? _____

_____

_____

Childhood eating habits: _____

_____

_____

Are there any foods groups excluded from your child's diet? Why? _____

_____

GENERAL QUESTIONS:

Has your child ever experienced any trauma? (***please circle***)

Fractures:	No	Yes
Accidents:	No	Yes
Emotional:	No	Yes

Please describe if you answered yes to any trauma:

_____

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Has your child ever been hospitalized? No Yes If yes please describe why and what year

_____

_____

Is your child taking any medications or supplements? No Yes If yes, please list what and quantity: _____

_____

How many times has your child taken antibiotics? _____

Do you live close to any of the following? (***please circle***)

Industry Power lines Highway Dump Airport

How would you describe your child's daycare or school experience (if appropriate) in terms of performance, enjoyment and socialization?

_____

_____

Has your child had any specialized screening tests? Please explain.

_____

_____

What are your child's interests?

_____

_____

How many days/week does your child participate in out-of-school programs?

_____

Would you characterize your home environment as (***please circle***):

Very stable Stable Stressful Very stressful

How many hours per day does your child use: TV _____ Computer _____ Video games _____

Have you done any major renovations to your home recently? _____

How old is your home? _____

How long have you lived there? _____

Are there any pets in your household? _____

Is the child exposed to tobacco smoke? _____

Does your child have any drug allergies? Please describe _____

_____

Does your child have any food allergies? Please describe _____

_____

Has your child ever traveled outside of Canada? Where and when? _____

_____

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GENERAL SYMPTOMS: (please check current symptoms, uses a **P** to indicate for past)

Acne		Slow wound healing	
Eczema, rashes		Sore throat	
Hives, itching		Coughing	
Changes in skin odour		Lumps, swollen glands	
Changes in hair/nails		Discharge (eyes, ears, nose, other)	
Cradle cap		High fevers	
Recent weight change		Anemia	
Weakness, fatigue		Vision problems	
Muscle or joint pain/stiffness		Hearing problems	
Change in posture/gait		Heat and/or cold intolerance	
Trouble chewing/swallowing		Excessive sweating	
Change in appetite		Night sweats	
Excessive/diminished thirst		Cries easily, weepy	
Excessive/diminished hunger		Nervous	
Diarrhea		Irritable	
Constipation		Sudden change in mood	
Frequent vomiting		Strong fears or aversions	
Stomach/abdominal aches		Nightmares, night terrors	
Excessive belching		Memory problems	
Excessive gas		Wheezing, difficulty breathing	
# of bowel movements/day		Body/breath odour	
Burning urination		Motion sickness	
Bed wetting		Joint pain	
Frequent urination		Easy bruising	
Blood in urine		Nose bleeds	
Age at potty training		Is child fully potty trained?	

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SLEEP:
Sleep patterns during first year? _____
Usual time child goes to bed and awakens: _____
Any napping during the day? No Yes, if yes please detail: _____
Difficulties in falling asleep and staying awake? _____

SENSITIVITIES:
Is your child particularly sensitive to any of the following? (please circle)

Claustrophobia	Drafts	Heat	Smells	Wool
Cold	Heights	Music	Sunlight	Wind

Briefly describe your child's personality including both positive and negative characteristics:
_____
_____
_____
Is there anything else you would like to add that you feel may be relevant to your child's case?
_____
_____
_____

Thank you for completing this form as accurately and completely as possible. It will greatly help the doctor to obtain a more complete understanding of your child.

INFORMED CONSENT

I _____, parent/guardian of _____
consent to treatment given to my child by Dr. Vanessa DiCicco ND/Dr. Jonathan Bablad ND.

Signature: _____

Date: _____

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