Naturopathic Pediatric Health Assessment

Name of Child _____ Date of birth _____ Sex: M F Date _____

Address _____

City _____ State _____ Zip _____

Phone _____ Other phone _____

Name of Mother _____ Occupation _____

Name of Father _____ Occupation _____

Living with ❑ Mother ❑ Father ❑ Guardian _____

MAJOR HEALTH CONCERNS (IN ORDER OF IMPORTANCE) **SINCE** **CAUSE**

1. _____
2. _____
3. _____

Is there any condition, trauma, or incident after which your child has never been totally well again? ❑ No ❑ Yes; If so, what?

_____

_____

SYMPTOMS (MARK "N" FOR CURRENT SYMPTOMS AND "P" FOR PAST SYMPTOMS)

___ Acne
___ Hives
___ Hair Loss
___ Eczema
___ Chronic Rash
___ Cradle Cap
___ Asthma
___ Pneumonia
___ Wheezing
___ Rubella
___ Measles
___ Tonsilitis/Strep
___ Mumps
___ Rheumatic Fever
___ Scarlet Fever
___ Chicken Pox
___ Ear Infections
___ Thrush
___ Sinus Infections
___ Frequent Urination
___ Burning Urination
___ Bloody Urine
___ Anemia
___ Easy Bruising
___ Bleeding Tendency
___ Nosebleeds
___ Dizzy Spells
___ Hearing Loss
___ Motion/Car Sickness
___ Nervous
___ Frequent Headaches
___ Joint Pains
___ Flat Feet
___ Excessive Fatigue
___ Unusual Fears
___ Cries Easily
___ Heart Murmur
___ Sensitive to Light

IMMUNIZATIONS

___ Measles, Mumps, Rubells (MMR) ___ Diptheria, Pertussis, Tetanus (DPT) ___ Small Pox

___ Influenza ___ Polio ___ Others _____

Any reactions to any of the above? ❑ No ❑ Yes; If so, which ones and what type of reaction was experienced?

_____

PRENATAL & BIRTH HISTORY

Fullterm, premature, late _____ Complications, if any _____

Length of labor _____ Vaginal or c-section _____

Child's birth weight _____ Anesthetics, drugs _____

Mother's age at conception _____

ANY OF THE FOLLOWING PROBLEMS FOR MOTHER DURING THE PREGNANCY?

___ Anemia
___ Spotting, Bleeding
___ Morning Sickness
___ Kidney/Bladder Infections
___ Vaginal Infections
___ High Blood Sugar
___ High Blood Pressure
___ Varicose Veins
___ Thyroid Problems
___ Preeclampsia/Eclampsia
___ Excess Sugar Use
___ Excess Alcohol Use
___ Recreational Drug Use
___ Abortions/Miscarriages
___ Emotional Trauma
___ Physical Trauma
___ Other _____
_____

DEVELOPMENTAL HISTORY (IF PATIENT IS LESS THAN 3 YEARS OLD)

Any of the following problems during infancy?

___ Birth Defects
___ "Blue Baby"
___ Cerebral Palsy
___ Diarrhea/Constipation
___ Feeding Difficulties
___ Fever
___ Jaundice
___ Rashes
___ Seizures
___ Colic
___ Injuries
___ Other _____

Was child breastfed? ❑ No ❑ Yes; for how long?_____ Any problems? _____

Was child put on formula? ❑ No ❑ Yes; what kind? _____ Any problems? _____

Age at which solid foods introduced _____ Food introduced _____

Please indicate if there were any problems with the following and age when activity first started	**Age**
Holding head up while on stomach _____	_____
Rolling from front to back and back to front _____	_____
Sitting with and without support _____	_____
Crawling _____	_____
Teething _____	_____
Talking (first word, combination of words, sentences) _____	_____
Walking with and without support _____	_____
Toilet training _____	_____
Any particular habits (thumb sucking, nail biting, head banging, rocking)_____	_____
Were there any nightmares, terrors, or sleepwalking? _____	_____

DENTAL/VISION HISTORY

Last Dental Exam _____

Describe any dental work done _____

What is the oral hygiene practice of the child? _____

Is your child's toothpaste fluoridated? ❑ No ❑ Yes Does your child have bleeding gums? ❑ No ❑ Yes

Describe any vision problems _____

FAMILY HISTORY (INDICATE MATERNAL WITH "M" AND PATERNAL WITH "P")

___ Alcohol	___ Bleeding	___ Epilepsy/Seizures	___ Mental Illness
___ Allergies/Hay fever	___ Birth Defects	___ Glaucoma	___ Stroke
___ Anemia	___ Cancer	___ Heart Disease	___ Thyroid (hyper/hypo)
___ Arthritis	___ Diabetes	___ High Blood Pressure	___ Tuberculosis
___ Asthma	___ Eczema	___ Kidney Disease	___ Other _____

DIGESTION

___ Weak appetite	___ Excess gas	___ Canker sores	___ Formed
___ Strong appetite	___ Abdominal pains	___ Bloating	___ Soft
___ Body/breath odor	___ Vomiting	___ # Bowel movements/day	Stool color _____

SLEEP

___ Light	___ Lacking	___ Bedwetting	___ Difficulty falling asleep
___ Deep	___ Excess	___ Night sweats	___ Nightmares

Position _____

IMMUNE SYSTEM

___ Good	___ Frequent colds/flu	___ Sore throat	___ High fevers
___ Poor	___ Chronic coughs		

MENTAL/EMOTIONAL

How does your child express the following emotions?

Anger _____

Sadness _____

Anxiety _____

Happiness _____

Fear _____

What fears does your child have _____

List major experiences of grief/loss in your child's life and how your child has coped with them: _____

_____

DIET DIARY

Please record what he/she eats for three days including drinks, snacks and supplements

	Breakfast	Snack	Lunch	Snack	Dinner
Day 1					
Day 2					
Day 3					

How many meals are generally eaten each day? ❑One ❑Two ❑Three ❑More than three

How often does he/she skip meals? ❑Never ❑Once or twice/month ❑Once/week ❑More than once/week

List foods excluded from his/her diet and why _____

_____

_____

List any foods he/she craves, regardless of their nutritional value _____

_____

_____

List any foods he/she is allergic to or has a bad reaction to and how he/she reacts _____

_____

_____

Is he/she thirsty? ❑ No ❑ Yes Amount of plain water he/she drinks each day _____

_____