*Fredericton Naturopathic Clinic*
**Drs. Parissa and Judah Bunin, Naturopathic Doctors**
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**Dear parent / guardian,**
**Please fill out this form and bring it with you on the first visit. Please note that all information disclosed is *confidential and will not be released* without your permission.**

Child's name:_____ Date:_____

Address:_____

Postal Code:_____ Age:_____ Sex:_____ Birth date:_____

Parent or Guardian's name:_____ Occupation:_____

Address (if different from above):_____

Telephone (Home): _____ (Work): _____

Name of family physician: _____ Telephone: _____

How did you hear about this clinic?_____

List reason(s) for your visit in order of importance (include date of onset with each concern):

1. _____
2. _____
3. _____

Is your child currently receiving any treatment for these concerns? Have they been effective?

_____

List any medication he/she is taking or has taken in the past (include duration, dosage and frequency): _____

_____

List any vitamin, mineral, or herbal supplements he/she is taking or has taken in the past (include duration, dosage and frequency): _____

_____

List any screening tests done recently (blood work, X-rays, etc.; include year and results):

_____

List any surgeries: _____

List any hospitalizations, accidents or serious injuries: _____

_____

List any known allergies or intolerances: _____

**IMMUNIZATIONS**

- ❑ Measles, mumps, rubella
- ❑ Diphtheria, pertussis, tetanus
- ❑ Polio
- ❑ Influenza
- ❑ Small pox
- ❑ Hepatitis
- ❑ Other? _____

*Has he/she had any adverse reactions to any immunizations?*_____

**FAMILY HISTORY**

*Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:*

- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Kidney Disease
- ❑ Headaches
- ❑ Epilepsy
- ❑ Mental Illness
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Allergies
- ❑ Cancer
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defects
- ❑ Anemia
- ❑ Other?_____

**CHILDHOOD ILLNESSES**

*Has he/she ever had any of the following?*

- ❑ Chicken Pox
- ❑ Measles
- ❑ Polio
- ❑ Scarlet fever
- ❑ Other?_____
- ❑ Ear Infections
- ❑ Mumps
- ❑ Rheumatic fever
- ❑ Tonsilitis
- ❑ Frequent Colds
- ❑ Pneumonia
- ❑ Rubella
- ❑ Whooping Cough

| **PRENATAL HISTORY** | **poor** | **fair** | **good** | **excellent** |
|---|---|---|---|---|
| Health of father at conception: | o | o | o | o |
| Health of mother at conception: | o | o | o | o |
| Physical health of mother during pregnancy: | o | o | o | o |
| Emotional health of mother during pregnancy: | o | o | o | o |
| Emotional health of mother following pregnancy: | o | o | o | o |
| Mother's diet during pregnancy: | o | o | o | o |

Number of pregnancies: ____ Number of miscarriages: ____ Mother's age at birth of child: ____

List any illness or other difficulties during pregnancy: _____

_____

Indicate any drug or alcohol consumption or cigarette smoking during pregnancy. (circle)

List any medication, supplements or herbal remedies taken during pregnancy: _____

_____

**LABOR AND DELIVERY**

Location of birth: _____ Duration of labor: _____

Description of birth

- ❑ Induced
- ❑ Spontaneous
- ❑ C-section
- ❑ Forceps
- ❑ Epidural
- ❑ C-section
- ❑ Natural
- ❑ Late
- ❑ Premature
- ❑ Other?

**NEONATAL HISTORY**

List any difficulties or complications soon after birth: _____

List any therapies or medications administered: _____

| | poor | fair | good | excellent |
|---|---|---|---|---|
| Health of child at birth: | o | o | o | o |
| Health of child in first year: | o | o | o | o |
| Sleep patterns in first year of life: | o | o | o | o |

**NUTRITION**

- ❑ Breast fed? How long? _____
- ❑ Formula? Describe: _____
- ❑ Milk? What type? Cow / goat / soy / nut / other _____

Current weight: _____ Current height: _____

Age of introduction to solid foods: _____ What foods introduced first?_____

Favorite foods: _____ Excluded foods: _____

*Does he/she consume any of the following at least once a week?*

- ❑ Sweets
- ❑ Fried Foods
- ❑ Luncheon Meats
- ❑ Distilled Water
- ❑ Excess Salt
- ❑ Margarine
- ❑ Soft Drinks
- ❑ Artificial Sweetener

**GROWTH AND DEVELOPMENT**

*Age he/she began:*

Crawling: _____ Toilet training: _____

Sitting: _____ Teething: _____

Walking alone: _____ Saying first words: _____

Any concerns (by parents and / or teachers) in regards to his/her physical, social or mental development ? _____

**LIFESTYLE / ENVIRONMENTAL FACTORS**

Is he/she exposed to any chemicals at home or at school? Explain: _____

What are his/her hobbies? _____

How is his/her energy level? Rate on scale of 1 to 10 (1=very low; 10=excellent) _____

Emotional climate at home: o very stable o stable o stressful o very stressful

How old is his/her residence? _____ Type of heating: _____ Any pets? ___

Type of flooring (hardwood, linoleum, carpets, rugs, etc.): _____

Has your child ever traveled outside your community? o Yes o No

Where? _____ When? _____

What was your child's response? _____

**REVIEW OF SYSTEMS**

*Please check off any conditions your child* ***currently has*** (indicate with ✓) *or* ***has had in the past*** (indicate with ×):

**General:**

- ❑ Poor appetite
- ❑ Intolerance to heat/cold
- ❑ Fatigue/weakness
- ❑ Change in thirst
- ❑ Sleep difficulties
- ❑ Fever/chills
- ❑ Significant weight change
- ❑ Other? _____

**Skin:**

- ❑ Rash / hives
- ❑ Lumps
- ❑ Nail problems/changes
- ❑ Eczema
- ❑ Birthmarks
- ❑ Easy Bruising
- ❑ Itching
- ❑ Hair problems/changes
- ❑ Jaundice
- ❑ Other?_____

**Head:**

- ❑ Headaches
- ❑ Abnormal size/shape of head
- ❑ Vision problems
- ❑ Hearing problems
- ❑ Ringing/buzzing in ear(s)
- ❑ Nosebleeds
- ❑ Frequent nasal discharge
- ❑ Dizziness
- ❑ Injuries
- ❑ Crossed-Eyes
- ❑ Ear infections
- ❑ Cradle cap
- ❑ Nasal Congestion
- ❑ Other?_____

**Mouth, throat & neck:**

- ❑ Frequent sore throats
- ❑ Chronic bad breath
- ❑ Speech difficulties
- ❑ Swollen glands
- ❑ Sore tongue/mouth/gums
- ❑ Dental Cavities
- ❑ Cold Sores
- ❑ Other?_____

**Respiratory system:**

- ❑ Chronic cough
- ❑ Breathing noises (e.g. wheezing)
- ❑ Chest pain
- ❑ Sputum/phlegm
- ❑ Shortness of breath/difficulty breathing
- ❑ Other?_____

**Heart & circulation:**

- ❑ Murmurs
- ❑ Other?_____
- ❑ Cold extremities

**Abdomen & gastrointestinal system:**

- ❑ Change in appetite
- ❑ Nausea/vomiting
- ❑ Belching /flatus
- ❑ Diarrhea
- ❑ Hernias
- ❑ Abdominal pain
- ❑ Change in stool color
- ❑ Change in bowel habit
- ❑ Change in thirst
- ❑ Blood in stool
- ❑ Colic or indigestion
- ❑ Constipation
- ❑ Food allergies/intolerances
- ❑ Hepatitis
- ❑ Change in stool odor
- ❑ Other?_____

**Urinary system:**

- ❑ Urinary frequency
- ❑ Sense of urgency
- ❑ Dribbling
- ❑ Difficulty passing urine
- ❑ Frequent infections
- ❑ Other?_____
- ❑ Bed wetting
- ❑ Pain on urination
- ❑ Hesitancy (difficulty starting)
- ❑ Blood in urine
- ❑ Change in color

**Musculoskeletal:**

- ❑ Broken bones
- ❑ Weakness
- ❑ Back pain
- ❑ Muscle cramps
- ❑ Bone pain
- ❑ Other?_____

**Nervous system:**

- ❑ Fainting
- ❑ Numbness/tingling
- ❑ Paralysis
- ❑ Seizures/convulsions
- ❑ Bone pain
- ❑ Other?_____

Please use the space below to include any further information regarding your child's personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider: _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of parent / guardian:_____ Date:_____