Holistic Healing Arts
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Registration #1638

Child's name _____ Date of birth _____

Date _____ Gender: _____ Referred by _____

Who is filling out this form (name and relation)? _____

Contacts (in order of preference)

Name _____ Address _____ _____ _____	Phone: home _____ work _____ Other _____
Relationship to child _____	
Name _____ Address _____ _____ _____	Phone: home _____ work _____ Other _____
Relationship to child _____	
Name _____ Address _____ _____ _____	Phone: home _____ work _____ Other _____

Relationship to child _____

May we leave messages relating to your visits? Y / N Which Phone Number? _____

Whom does the child live with? _____

Does your insurance cover consultations for a Naturopathic Doctor? Y / N

How did you hear about the clinic? _____

Other health care providers

1.	2.	3.
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____

What are your child's health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____
_____
_____
_____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s rubella (german measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chicken pox	n m a s whooping cough	n m a s ear infections
n m a s mumps	n m a s strep throat	

Does your child have any allergies (medicines, environmental, etc.)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis B
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Polio	

Other _____

Please indicate if any caused adverse reactions

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

Prenatal health

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding	☐ High blood pressure	☐ Nausea	☐ Vomiting
☐ Diabetes	☐ Thyroid problems	☐ Physical or emotional trauma	

Other _____

_____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries

_____

☐ Birth defects _____

☐ Other _____

Diet

How was your infant fed?

☐ Breast fed. How long? _____ ☐ Formula. Milk/Soy/Other: _____

☐ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

_____

_____

_____

6–12 months?

_____

_____

_____

_____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

_____

_____

_____

_____

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

_____

_____

Describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern _____

_____

_____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at school?

_____

_____

Family history

Indicate if a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family medical history

Do either of the parents have a chronic illness? Y N Please describe

_____

Environment

Is the child in: school daycare home care other _____

What are your child's favorite activities? _____

_____

Does the child exercise regularly? Y N How much, how often?

_____

_____

How much television does your child watch? _____ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____

_____

_____

_____

How would you describe the emotional climate of the child's home?

_____

_____

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

_____

For file use only

Thank you for taking the time to fill out this form.