THRIVE
Chiropractic & Wellness Centre

Child Health Questionnaire

PERSONAL INFORMATION

Name: _____ Today's Date: _____
Date of Birth:_____(d/m/y) Age:_____ Gender: M☐ F☐ AB health care #: _____
Home Address:_____ City: _____ Prov: _____
Postal Code:_____ Phone (home):_____ Phone (other):_____
E-mail Address: _____
Ethnicity: _____ *(for genetic health risk assessment purposes only)*

Mother or Legal Guardian's Name: _____
Address: (if different from above): _____
Phone (home):_____ Phone (cell):_____ Phone (work):_____
Occupation: _____
Father or Legal Guardian's Name: _____
Address: (if different from above): _____
Phone (home):_____ Phone (cell):_____ Phone (work):_____
Occupation: _____

Emergency Contact: _____ Relation:_____ Phone: _____

I consent to receiving free ongoing support and guidance via email to help my child achieve better results in their health: Yes ☐ No ☐

List of Other Healthcare Providers:
Medical Doctor(s):_____ Phone: _____
Naturopathic Doctor: _____ Phone: _____
Chiropractor: _____ Phone: _____
Others:_____ Phone: _____

How did you hear about Dr. Haarsma?
Dr. Haarsma's website ☐ Clinic website ☐ Referral/Recommended ☐ Internet reviews ☐
Facebook ☐ Instagram ☐ Other Social Media ☐ Other ☐ (please specify):_____

Has your child been treated by a Naturopathic Doctor before? *Y or N*
If 'yes', by whom? _____ When? _____
For what reason(s)? _____

What is the main reason you are seeking naturopathic care for your child?

_____

_____

_____

CONFIDENTIAL HEALTH QUESTIONNAIRE

This is a general pediatric form, depending on the age of your child this may not all apply, or you may not remember; for those sections that do not apply please indicate with "NA".

Has your child had similar health concerns before? _____ Explain: _____

_____

Does your child have any relatives with similar problems? _____

What do you feel is causing the health problems your child may have? _____

_____

When did your child last feel well? _____

What long-term expectations do you as a parent have from working with this clinic?

_____

_____

What expectations do you have of me personally as your physician? _____

_____

What behaviours or lifestyle habits does your child currently engage in regularly that you believe support his/her health? Please list.

_____

_____

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self-destructive to their health? Please list.

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols that I will be sharing with you?

_____

_____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes your child will be making?

_____

What is your present level of commitment to address any underlying causes of your child's health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

1 2 3 4 5 6 7 8 9 10

MEDICATIONS

How many times has your child been treated with antibiotics?_____ When was the last time?_____
Main reason for antibiotic use: □ Ear Infections □ Bronchitis □ Pneumonia □ Sinus Infection
□ Intestinal Infection □ Other (please explain)_____
Was your child ever treated for a yeast infection following antibiotic use _____

Please list all **"current"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"current"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

HEALTH HISTORY

Does your child have any known contagious diseases at this time? *Y N* If yes, what?_____

How would you describe your child's current state of health (circle)? *Excellent Good Fair Poor*

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has had. Include approximate dates.

_____

_____

List any X-rays, CT scans, or other studies that your child has had.

_____

_____

Significant physical or emotional trauma: _____

Type of birth: □ Vaginal □ C-section

Allergies: Is your child sensitive or allergic to…

Any drugs?_____ Any environmentals?_____

Any chemicals?_____ Any supplements?_____

Any food allergies or intolerances?_____

Childhood Illnesses: (check those that apply). Which of the following conditions has your child had?

☐ Asthma/Wheezing	☐ Cradle cap	☐ Frequent colds	☐ Night sweats
☐ Bedwetting	☐ Cries easily	☐ Frequent urination	☐ Nose bleeds
☐ Body/breath odor	☐ Croup	☐ Hair loss	☐ Rubella
☐ Burning of urine	☐ Diaper rash	☐ Heart disease	☐ Seizures
☐ Canker sores	☐ Diarrhea	☐ Heat intolerance	☐ Sore throats
☐ Change in appetite	☐ Dizzy spells	☐ High fevers	☐ Stomach aches
☐ Chicken pox	☐ Easy bruising	☐ Measles	☐ Strep throat
☐ Cold intolerance	☐ Eczema	☐ Mumps	☐ Tonsillitis
☐ Constipation	☐ Fatigue	☐ Nervous	☐ Whooping cough

☐ Unusual fears, describe:_____

☐ Ear infections – How many and how often?_____

☐ Other:_____

Immunizations: What immunizations has your child had?

☐ DPT (diphtheria, pertussis, tetanus)	☐ Hepatitis A	☐ Flu shot
☐ Haemophilus influenza B	☐ Hepatitis B	☐ Polio
☐ MMR (measles, mumps, rubella)	☐ Hepatitis C	☐ Smallpox
☐ Chicken pox	☐ Other: _____	

Please indicate any adverse reactions your child has experienced from an immunization.

_____

Digestive Health:

Does child have periodic loose stools/diarrhea? *Y / N* Offensive Gas? *Y / N*

Undigested food in stool? *Y / N* Is your child potty trained? *Y / N*

Does your child suffer with reflux/heartburn? *Y / N* Bloating after eating? *Y / N*

Does your child produce formed stools? *Y / N*

Is your child currently taking an acid-blocking medication such as Losec, Pepcid, etc? *Y / N*

Did occurrence of digestive problems occur following a particular vaccine? *Y / N / Unsure*

Diet: Describe a typical day's diet.

Breakfast_____

Lunch_____

Supper_____

Snacks_____

How many cups/bottles/glasses does your child drink on average per day?

Beverage	**Amount**	**Beverage**	**Amount**	**Beverage**	**Amount**
Water		Fruit juice		Soft drinks regular	
Milk		Vegetable juice		Soft drinks diet	
Soy milk		Herbal Tea		Caffeine/energy drinks	

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

Feeding History:

☐ Breast ☐ Bottle What kind of formula?_____ How long for either?_____
Did your infant experience any reactions to formula or breast milk?_____
_____ _____

Please list any foods that were introduced before 6 months, as well as any reactions noted:
_____ _____
_____ _____

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?
_____ _____
_____ _____

Does your child have any cravings?_____

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).
_____ _____

Prenatal Health and History:

What was the health of the parents at the time just prior to conception (please circle)?
Mother: *Poor Fair Good Excellent Unknown*
Father: *Poor Fair Good Excellent Unknown*
What was the health of the mother during pregnancy? *Poor Fair Good Excellent Unknown*

Emotional state during pregnancy? *Poor Fair Good Excellent Unknown*

On a scale of 1 - 10 (10 being highest), while pregnant, please rate your stress____ & energy levels____ .

Any new events/changes/symptoms/conditions in your life that occurred during pregnancy?

Y / N _____

How was the mother's diet during pregnancy? *Poor Fair Good Excellent Unknown*

Did the mother exercise during pregnancy? *Y / N* Type:_____Duration:_____Frequency:_____

What was the mother's age at the time of the child's birth?_____Occupation during pregnancy?_____

How many previous pregnancies _____and births_____?

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid problems ☐ Trauma ☐ Forced bed rest

☐ Other:_____

Did the mother receive medical care during pregnancy and/or delivery? *Yes No Unknown.*

If yes, why?_____

Were any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Amniocentesis ☐ Chorionic villi sampling ☐ Triple Screen

☐ Maternal serum screening ☐ Other:_____ _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:_____

☐ Prescription medications (incl antibiotics):_____

☐ Over-the-counter medications: _____

☐ Vitamins and/or supplements: _____

Coffee: *Y / N* _____cups/d Soft drinks: *Y / N* _____cups/d Artificial sweeteners: *Y / N*

Did you consume dairy products? *Y / N*

Birth History: (please complete if your child is less than 2 years old)

Term length: ☐ Pre-term (37 weeks or less): ___ weeks ☐ Full-term (38-42 weeks): ___ weeks
☐ Post-term (more than 42 weeks): ____ weeks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Midwife ☐Other:_____

Types of Intervention: ☐ Induction ☐ Forceps/suction ☐ Epidural/anesthesia ☐ Episiotomy
☐ Other: _____

Were there any complications during delivery (e.g., breech, induction)?_____
_____ _____

Length of labour: _____ Weight of infant at birth:_____Length of infant at birth:_____

APGAR score (0 to 10): 1minute _____ 2 minutes _____ 5 minutes:_____

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

☐ Anemia ☐ Bradycardia ☐ Cyanosis ☐ Congenital defects:_____
☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries:_____
☐ Infections:_____ ☐ Breathing difficulty:_____
☐ Difficulties with feeding:_____ ☐ Colic:_____*mild*_____*moderate*_____*severe*
☐ Birth defects:_____ ☐ Atrioventricular septal defect:_____
☐ Other: _____

Please write any details pertaining to the birth experience that you feel are important to their well-being:

_____
_____

Developmental Milestones:

How was your child's health in the first year? *Poor Fair Good Excellent Unknown*
How is your child's health now? *Poor Fair Good Excellent Unknown*
At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____
At what age did your child begin teething? _____ Were there any difficulties associated with it?
_____

Sleep Patterns:

What time does your child usually go to bed?_____ wake in the morning?_____
How many times does your child wake during the night?_____ Does your child wake rested? *Y / N*
Does your child nap? *Y / N* Length of nap:____
Does your child have nightmares? *Y / N* Please describe (ie theme, how often)_____
Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, bed wetting, etc.)?
_____ _____
_____ _____

Social History:

Are parents divorced? *Y / N* Number of siblings (birth order):_____
Is your child in: ☐ school ☐ daycare ☐ home care ☐ other:_____
How would you describe your child's behaviour at school? _____
_____ _____
How would you describe your child's behaviour at home?_____
_____ _____
What are your child's interests and favourite activities? _____
_____ _____
What is your child's least favourite thing to do? _____
_____ _____
What recreational activities is your child involved in?_____
_____ _____
Describe your child's temperament/personality?_____
_____
Please describe any worries or fears your child has: _____
_____ _____
_____ _____
Does your child exercise regularly? *Y / N* Type, duration, frequency?_____
_____ _____
How much television does your child watch? _____ hours a day/week
How often does your child play video games? _____ hours 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
Is there anything regarding this child that should not be mentioned in his/her presence?
_____
_____

Family History:

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

Condition	Relative(s)	Condition	Relative(s)	Condition	Relative(s)
☐ Alcoholism		☐ Depression		☐ Learning disabilities	
☐ Allergies		☐ Diabetes		☐ Mental Illness	
☐ Anemia		☐ Eczema		☐ Multiple sclerosis	
☐ Arthritis		☐ Epilepsy		☐ Muscular dystrophy	
☐ Asthma		☐ Glaucoma		☐ Seizures	
☐ Bed wetting		☐ Heart disease		☐ Stomach ulcers	
☐ Birth defects		☐ Hay Fever		☐ Stroke	
☐ Bleeding disorder		☐ High Blood Pressure		☐ Tuberculosis	
☐ Cancer		☐ Hyperactivity		☐ Yeast infection	
☐ Celiac disease		☐ Juvenile Arthritis		☐ Venereal disease	
☐ Colitis		☐ Kidney Disease		☐ Other:_____	

☐ I don't know the family medical history

Please fill in the following chart, based on the child's relatives:

Relation	Age (if living)	If deceased, at what age & cause of death?
Mother		
Father		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Do either of the parents have a chronic illness? *Y / N* Please describe._____

_____ _____

_____ _____

Home Environment:

Are there any pets in the home? *Y / N* What type and how many?_____

_____ _____

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

Age of home _____ Carpet (age, type):_____ How is the child's home heated?_____

Lead paint (old home, age):_____ Is home located near a power line and/or cell phone tower? *Y / N*

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

_____ _____

_____ _____

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

_____ _____

_____ _____

_____ _____

Does your child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odours, soaps, etc.)?_____

_____ _____

_____ _____

General Info:

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

_____ _____

_____ _____

_____ _____

_____ _____

Consent Form

Naturopathic medicine is a style of medicine which addresses individual health, condition treatment and disease prevention primarily by natural means. Naturopathic Doctors consider the whole person taking into account physical, biochemical, mental and emotional aspects of each person and work to find the root cause of disease and to stimulate the innate healing ability of the body.

There is a slight potential for risk involved in naturopathic medical care. These risks include but are not limited to the following:

- Allergic reaction to supplements, herbs, topical products or injectable components
- Aggravation of pre-existing symptoms or condition(s)
- Mild pain, bruising or minor bleeding following acupuncture, injection therapies or venipuncture

I _____(guardian) understand that my identity and the identity of my child will be protected at all times and that a health record will be kept detailing health services provided to my child. This record will be kept confidential and will only be released under my specific direction or as required by law. I also consent to the use of information in my child's medical record for research purposes and understand that my identity and that of my child will always be protected and kept absolutely confidential.

I commit to informing my Naturopathic Doctor immediately of any disease or condition my child suffers from and will continue to update my Naturopathic Doctor with all pertinent changes in my child's health.

I understand that the Naturopathic Doctor will answer any of my questions to the best of her ability. I understand that results are not guaranteed. I do not expect the Naturopathic Doctor to anticipate and explain all risks and potential complications involved in naturopathic care. With this knowledge, I voluntarily consent to diagnostic and treatment procedures by my Naturopathic Doctor. I understand that my consent, as indicated on this form, will cover the entire duration of my child's clinical relationship with his/her naturopathic doctor. I also understand that I am free to withdraw this consent through written notification and may discontinue participation in any procedure at any time.

Patient Name: (please print) _____

Name of Guardian: (please print) _____

Signature of Patient or Guardian: _____

Date: _____