

***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

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Measles, mumps, rubella        | <input type="checkbox"/> Small pox    |
| <input type="checkbox"/> Diphtheria, pertussis, tetanus | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Polio                          | <input type="checkbox"/> Other? _____ |
| <input type="checkbox"/> Influenza                      |                                       |

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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Anemia        |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Other? _____  |

## CHILDHOOD ILLNESSES

Has he/she ever had any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Pneumonia      |
| <input type="checkbox"/> Polio         | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rubella        |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Tonsillitis     | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Other? _____  |  |   |

## PRENATAL HISTORY

	poor	fair	good	excellent
Health of father at conception:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health of mother at conception:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical health of mother during pregnancy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional health of mother during pregnancy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional health of mother following pregnancy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother's diet during pregnancy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- |                                      |                                    |                                    |                                  |                                    |
|--------------------------------------|------------------------------------|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Induced     | <input type="checkbox"/> C-section | <input type="checkbox"/> Epidural  | <input type="checkbox"/> Natural | <input type="checkbox"/> Premature |
| <input type="checkbox"/> Spontaneous | <input type="checkbox"/> Forceps   | <input type="checkbox"/> C-section | <input type="checkbox"/> Late    | <input type="checkbox"/> Other?    |

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Head circumference: \_\_\_\_\_

## NEONATAL HISTORY

List any difficulties or complications soon after birth: \_\_\_\_\_

List any therapies or medications administered: \_\_\_\_\_

	<b>poor</b>	<b>fair</b>	<b>good</b>	<b>excellent</b>
Health of child at birth:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health of child in first year:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep patterns in first year of life:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

## GROWTH AND DEVELOPMENT

*Age he/she began:*

Crawling: \_\_\_\_\_

Sitting: \_\_\_\_\_

Walking alone: \_\_\_\_\_

Toilet training: \_\_\_\_\_

Teething: \_\_\_\_\_

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:  very stable  stable  stressful  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?  Yes  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:

- |   |  |
|---|--|
| <input type="checkbox"/> Poor appetite            | <input type="checkbox"/> Sleep difficulties        |
| <input type="checkbox"/> Intolerance to heat/cold | <input type="checkbox"/> Fever/chills              |
| <input type="checkbox"/> Fatigue/weakness         | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Change in thirst         | <input type="checkbox"/> Other? _____              |

### Skin:

- |  |  |
|--|--|
| <input type="checkbox"/> Rash / hives          | <input type="checkbox"/> Easy Bruising         |
| <input type="checkbox"/> Lumps                 | <input type="checkbox"/> Itching               |
| <input type="checkbox"/> Nail problems/changes | <input type="checkbox"/> Hair problems/changes |
| <input type="checkbox"/> Eczema                | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Birthmarks            | <input type="checkbox"/> Other? _____          |

### Head:

- |  |   |
|--|---|
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Dizziness        |
| <input type="checkbox"/> Abnormal size/shape of head | <input type="checkbox"/> Injuries         |
| <input type="checkbox"/> Vision problems             | <input type="checkbox"/> Crossed-Eyes     |
| <input type="checkbox"/> Hearing problems            | <input type="checkbox"/> Ear infections   |
| <input type="checkbox"/> Ringing/buzzing in ear(s)   | <input type="checkbox"/> Cradle cap       |
| <input type="checkbox"/> Nosebleeds                  | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Frequent nasal discharge    | <input type="checkbox"/> Other? _____     |

### Mouth, throat & neck:

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Sore tongue/mouth/gums |
| <input type="checkbox"/> Chronic bad breath    | <input type="checkbox"/> Dental Cavities        |
| <input type="checkbox"/> Speech difficulties   | <input type="checkbox"/> Cold Sores             |
| <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Other? _____           |

### Respiratory system:

- |   |   |
|---|---|
| <input type="checkbox"/> Chronic cough                    | <input type="checkbox"/> Sputum/phlegm                            |
| <input type="checkbox"/> Breathing noises (e.g. wheezing) | <input type="checkbox"/> Shortness of breath/difficulty breathing |
| <input type="checkbox"/> Chest pain                       | <input type="checkbox"/> Other? _____                             |

### Heart & circulation:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Murmurs      | <input type="checkbox"/> Cold extremities |
| <input type="checkbox"/> Other? _____ |   |

### Abdomen & gastrointestinal system:

- |  |  |
|--|--|
| <input type="checkbox"/> Change in appetite    | <input type="checkbox"/> Change in thirst            |
| <input type="checkbox"/> Nausea/vomiting       | <input type="checkbox"/> Blood in stool              |
| <input type="checkbox"/> Belching /flatus      | <input type="checkbox"/> Colic or indigestion        |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Constipation                |
| <input type="checkbox"/> Hernias               | <input type="checkbox"/> Food allergies/intolerances |
| <input type="checkbox"/> Abdominal pain        | <input type="checkbox"/> Hepatitis                   |
| <input type="checkbox"/> Change in stool color | <input type="checkbox"/> Change in stool odor        |
| <input type="checkbox"/> Change in bowel habit | <input type="checkbox"/> Other? _____                |

**Urinary system:**

- |   |  |
|---|--|
| <input type="checkbox"/> Urinary frequency        | <input type="checkbox"/> Bed wetting                     |
| <input type="checkbox"/> Sense of urgency         | <input type="checkbox"/> Pain on urination               |
| <input type="checkbox"/> Dribbling                | <input type="checkbox"/> Hesitancy (difficulty starting) |
| <input type="checkbox"/> Difficulty passing urine | <input type="checkbox"/> Blood in urine                  |
| <input type="checkbox"/> Frequent infections      | <input type="checkbox"/> Change in color                 |
| <input type="checkbox"/> Other? _____             |  |

**Musculoskeletal:**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Weakness     | <input type="checkbox"/> Bone pain     |
| <input type="checkbox"/> Back pain    | <input type="checkbox"/> Other? _____  |

**Nervous system:**

- |  |   |
|--|---|
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Bone pain            |
| <input type="checkbox"/> Paralysis         | <input type="checkbox"/> 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: \_\_\_\_\_

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Signature of parent / guardian: \_\_\_\_\_

Date: \_\_\_\_\_