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Date: _____

Your Name: _____ Relationship to Child: _____

Child's Name: _____Age: ___ Date Of Birth: _____

Child's Primary Residence:

Name: _____ Relationship to Child: _____

Address: _____

Phone: (Office): _____ (Home): _____

Alternate Residence/Contact:

Name: _____ Relationship to Child: _____

Address: _____

Phone: (Office): _____ (Home): _____

Referred By: _____

Health Concerns For Your Child:

1. _____ 3. _____

2. _____ 4. _____

Other Health Care Providers:

_____

_____

_____

List Medications / Supplements Your Child Is Currently Taking (Include Dosage):

_____

_____

_____

List Medications / Supplements Your Child Has Had In The Past:

_____

_____

Antibiotics? Yes No If Yes, How many Times? _____

List Any Major Illnesses or Injuries in Your Child's Life With Approximate Dates:

_____

_____

_____

Any Medical Or Environmental Allergies or Sensitivities?

_____

_____

Circle Any of The Following That Your Child Has Had:

German Measles (Rubella)	Roseola	Impetigo
Measles	Scarlet Fever	Mononucleosis
Chicken Pox	Mumps	Ear Infections
Whooping Cough	Strep Throat	

Please Indicate what Immunizations Your Child Has Had:

- ❑ The Usual Vaccination Protocol - Recommended By Your Medical Doctor
- ❑ Only The Following (please indicate):
  - o Pentacel (diptheria, pertussis, tetanus, polio, haemophilus)
  - o NeisVac-C (meningococcal)
  - o Prevnar (pneumococcal)
  - o Recombivax (hepatitis B)
  - o MMR2 (measles, mumps, rubella)
  - o DPT (diphtheria, pertussis, tetanus)
  - o Flu Shot
  - o Varivax3 (chicken pox)
  - o Tetanus Booster. When? _____
- ❑ Others: _____

Any Reactions To Immunizations? _____

_____

Prenatal Health

- The Child Was **Adopted** At Age_____.
- Information About The Mother's Pregnancy And Birth Are Unknown.

Mother's Age At Child's Birth: _____

Please Circle Any Of The Following That Were Experienced By The Mother During Pregnancy:

Bleeding	High Blood Pressure	Diabetes
Nausea	Vomiting	Thyroid Problems
Physical Injury	Emotional Stress	Other? _____

Please Indicate Which Of The Following Were Used By The Mother During Pregnancy:

- Tobacco. Frequency: _____ Alcohol. Frequency: _____
- Prescription Medication:_____
- Over-the-counter Medications:_____
- Supplements (Herbs, Vitamins...):_____
- Any Other? _____

Birth History

Premature? _____wks.		Late? _____wks.
Vaginal Birth	Epidural	Cesarian Section
Forceps	Induced	Other? _____

Length Of Labour: _____ Weight at Birth: _____
List Any Complications: _____

Please Indicate Any Of The Following Your Child Experienced Following Birth.

θ Jaundice θ Rashes θ Seizures
θ Birth Injuries: _____
θ Birth Defects: _____

Diet

θ Breastfed? _____Months. θ Formula? Type: _____

What Foods Were Introduced Before 1 year of age (In Order Of Introduction)?

_____

_____

_____

Did Your Child React To Any Of The Foods Introduced? Please Also Mention Any Known Food Sensitivities or Allergies.

_____

_____

_____

Describe A Typical Day's Diet:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____

Family History

Please Indicate If A Close Relative Has Had Any Of The Following:

θ Allergies	θ Diabetes	θ Asthma
θ Eczema	θ Kidney Disease	θ Arthritis
θ Cancer	θ Heart Disease	θ Tuberculosis
θ Gonorrhoea	θ Malaria	θ Depression

θ Others? _____

Social and Environmental Health

At What Age Did Your Child First: Sit Up? _____
Crawl? _____
Walk? _____
Talk? _____

Describe Your Child's Sleep Patterns: _____
Describe Your Child's Temperament: _____
Describe Your Child's Behaviour And Performance At School: _____
_____
Where Does The Child Mostly Spend His/Her Time? _____
_____
How Does Your Child Get Exercise? _____
_____
How Much Television Does Your Child Watch? _____
How Often Does Your Child Read or Get Read To? _____

Is Your Child Regularly Exposed To Tobacco Smoke? θ Yes θ No
Are There Animals In The Home? θ Yes θ No

How Would You Describe The Emotional Climate In Your Child's Home?

_____
_____

Consent Form

I _____ (Parent/Guardian's Name), acknowledge that I am aware naturopathic treatment and conventional medical treatments are not mutually exclusive and I am free to seek or continue medical care from the health practitioners of my choice for my child.

I hereby authorize and consent to naturopathic examination and treatment of

_____(child) by Dr. Megan Kimberley, BSc, N.D..

Signature: _____ Date: _____