Dr. Marie-Jasmine Parsi
Naturopathic Doctor

Pediatric Patient Information Form

Patient Information			
Last Name:	First Name:	Middle Name:	
Date of Birth (MM/DD/YYYY):	Age:	Sex: F ☐ M ☐	Who is filling out this form? (name, relationship):

Contact Information			
Full Address:		City, Province:	
Postal Code:	Daytime phone number:	Evening phone number:	May we leave messages regarding your visit? Y ☐ N ☐
Email:			

Emergency Contact Information		
1) Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	
2) Last Name:	First Name:	Relationship:
Daytime phone number:	Evening phone number:	

Other Healthcare Providers		
Name:	Name:	Name:
Speciality/Focus:	Speciality/Focus:	Speciality/Focus:
Phone number:	Phone number:	Phone number:
Date of last medical doctor visit:	Date of last physical exam:	
Please list regular screening tests performed by other physicians:		

How did you hear about this clinic?	
If referred, please state by whom:	
Have you been treated by a Naturopathic Doctor before? Yes ☐ No ☐	
If yes, by whom?	Date of last visit to ND:

Health Assessment Questionnaire

In your opinion, what are the child's most important health concerns?
1)
2)
3)
4)
5)

Medical History

Was the child adopted? Yes ☐ No ☐	Does the child receive regular age-specific screening exams? (hearing, vision, height, weight, etc) Yes ☐ No ☐
Current Height:	Current Weight:

Vaccination/Immunization Record – Check all that apply:
Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

- ☐ **DPT** (Diptheria, Pertussis, Tetanus)
- ☐ **MMR** (Measles, Mumps, Rubella)
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ BCG (Tuberculosis)
- ☐ Hepatitis A
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ Flu vaccine
- ☐ **Pneumococcal Conjugate** (Meningitis/Pneumonia)
- ☐ **Meningococcal C Conjugate** (Meningitis)
- ☐ **Varivax/Varilrix** (Chicken pox)

Other:
Did any of the vaccines cause adverse reactions? If yes please specify:

Which of the following childhood illnesses have you had? Check all that apply:

☐ Asthma	☐ Polio	☐ Mumps
☐ Rheumatic fever	☐ Scarlet fever	☐ Roseola
☐ Rubella (German measles)	☐ Whooping cough	☐ Measles
☐ Chicken pox	☐ Mononucleosis	☐ Skin concerns (eczema, etc.)
☐ Sinus concerns	☐ Ear infections	☐ Epilepsy
☐ Frequent colds	☐ Fractures	☐ Frequent nosebleeds
☐ Strep throat	☐ Tonsillitis	☐ Other:

List any previously diagnoses medical conditions:	Treatment received:	Year:
1)		
2)		
3)		
4)		
5)		

List all allergies (medications, foods, supplements, environmental, etc) 1)	**Reaction type:**
2)	
3)	
4)	
5)	

List all prescription drugs (antibiotics, etc.) **over-the-counter medications** (cold/flu formulas, etc) **herbs and natural supplements** (vitamins, homeopathics, etc) **the child is currently taking**:

Medication	Dosage	Start Date

Family Medical History

Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information

	Age	Health History		Age	Health History
Father			**Mother**		
Grandmother (maternal)			**Grandmother (paternal)**		
Grandfather (maternal)			**Grandfather (paternal)**		
Siblings		☐F ☐M	**Siblings**		☐F ☐M
		☐F ☐M			☐F ☐M

<table>
<tr><th colspan="3">Prenatal History</th></tr>
<tr><td>Pregnancy weight gain:</td><td colspan="2">Was the child conceived naturally? ☐ Yes ☐ No</td></tr>
<tr><td colspan="3">If fertility interventions were used, please indicate:</td></tr>
<tr><td>Mother’s age at conception:</td><td colspan="2">Father’s age at conception:</td></tr>
<tr><td colspan="3">Did the mother experience any of the following during pregnancy? Check all that apply:</td></tr>
<tr><td>☐ Excessive bleeding
☐ Diabetes
☐ Emotional trauma
☐ Other illnesses:</td><td>☐ Nausea
☐ Vomiting
☐ Physical trauma</td><td>☐ High blood pressure
☐ Thyroid concerns</td></tr>
<tr><td colspan="3">List all prescription drugs and over-the-counter medications taken during pregnancy:</td></tr>
<tr><td>Medication</td><td>Dosage</td><td>Start Date</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
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<tr><td colspan="3">List all herbs and natural supplements taken during pregnancy:</td></tr>
<tr><td>Medication</td><td>Dosage</td><td>Start Date</td></tr>
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<table>
<tr><th colspan="2">Natal (Birth) History</th></tr>
<tr><td>What type of delivery?
☐ Vaginal birth ☐ Hospital
☐ C-section ☐ Home-birth</td><td>Duration of labour:</td></tr>
<tr><td>Was the labour:
☐ Spontaneous? or ☐ Induced?</td><td>If there were difficulties, please describe:</td></tr>
<tr><td>Were any delivery interventions used?
☐Yes ☐No

If yes, which ones?
☐ Epidural ☐ Forceps
☐ Episiotomy ☐ Suction</td><td>Was mom Strep B positive? ☐Yes ☐No

If yes, were antibiotics used during birth?
☐Yes ☐No</td></tr>
<tr><td colspan="2">Term length: ☐Full / ☐ Premature: weeks / ☐ Overdue: weeks</td></tr>
<tr><td>Birth weight:
Birth length:</td><td>Apgar score at 1min:
5min:</td></tr>
<tr><td colspan="2">Did the baby experience any of the following at or after birth? Check all that apply</td></tr>
<tr><td>☐ Jaundice
☐ Seizures
☐ Rash
☐ Infections
☐ Respiratory distress</td><td>☐ Birth injuries
☐ Congenital conditions:
☐ Colic
☐ Poor feeding
☐ Other illnesses:</td></tr>
<tr><td colspan="2">Were any of the following interventions used:
☐ Silver nitrate drops / ☐ Vitamin K drops / ☐ Other:</td></tr>
</table>

<table>
<tr><th colspan="3">Dietary and Lifestyle Habits</th></tr>
<tr><td rowspan="5">Nutrition and Feeding</td><td>Was the child breastfed?
Yes ☐ No ☐</td><td>If yes, for how long?</td></tr>
<tr><td>Was the child breastfed?
Yes ☐ No ☐</td><td>If yes, when did he/she start?</td></tr>
<tr><td>When was solid food first introduced?</td><td>Please list the first foods introduced:</td></tr>
<tr><td colspan="2">Does the child follow a specific diet regime?
☐ Vegetarian / ☐ Vegan / ☐ Other:</td></tr>
<tr><td colspan="2">On average, how many meals does the child have in a day?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5 ☐</td></tr>
<tr><td rowspan="5">Sleeping and Resting</td><td>How many hours of sleep does the child get?</td><td>Does the child nap?
☐ Yes ☐ No</td></tr>
<tr><td>Does the child have trouble falling asleep? ☐ Yes ☐ No</td><td>What keeps him/her up?</td></tr>
<tr><td>Does the child sleep through the night? ☐ Yes ☐ No</td><td>If no, how often does he/she wake up?</td></tr>
<tr><td>Child’s usual sleep time:</td><td>Child’s usual wake-up time:</td></tr>
<tr><td colspan="2">Does the child: ☐ wet the bed / ☐ snore / ☐ have nightmares /
☐ sleep walk / ☐ talk in their sleep ?</td></tr>
<tr><td rowspan="4">Development and Social History</td><td colspan="2">Describe how the child interacts with siblings / friends:</td></tr>
<tr><td>Does the child exercise regularly?
☐ Yes / ☐ No</td><td>If yes, what type?</td></tr>
<tr><td colspan="2">In a typical day, how long does the child:
Watch TV: Play games: Use computer: ?</td></tr>
<tr><td colspan="2">At what age did the child first:
Sit up: Crawl: Walk: Talk:
Teeth: Toilet train: ?</td></tr>
</table>

Is there any other important information that you would like me to know?