Dr Anita Bratt ND
Naturopathic Physician

Child Health History Form

Name_____ Date _____
Age _____ M ☐ F ☐ Date of Birth (M/D/Y) _____/_____/_____
Care Card Number_____
Home Address_____
City _____ Province _____ Postal Code _____
Phone (H)_____ Email: _____
How did you hear of our clinic? If referred, please indicate by whom _____
_____
Parent/ Guardian Information:
Mother's Name _____Work Phone: _____
Occupation: _____ Cell # _____
Father's Name_____ Work Phone: _____
Occupation: _____ Cell # _____

Names of Healthcare Providers:
Medical Doctor(s) _____
Pediatrician _____ Other _____

Age at Autism or ADHD Diagnosis? _____ Symptoms became apparent at what age? _____
Any additional diagnosis given? List:_____

Developmental History
Sat at_____(months) Crawled at _____ Walked at_____ Talked at_____
Regression of speech? ___No ___Yes, at what age?_____
Was child breastfed? ___No ___Yes, if so how long? _____
Formula used? ___No ___Yes, if so introduced at what age?_____
Colic/irritability as baby? ___No ___Yes

Health Issues:
Does your child suffer with other health problems: ___ Allergies ___ Asthma ___ Kidney disease
___ Lung Disease ___ Diabetes ___ Thyroid Disease ___ Seizures ___ Heart Disease
___ Repeated Infections _____ Fatigue/lethargy ___Other- explain_____

Skin: ☐ Eczema ☐ Recurrent rashes ☐ Warts ☐ Cold sores ☐ Dry skin/bumps ☐ Itching
☐ Red cheeks +/or ears ☐ Dark circles under eyes ☐ White tongue ☐ Hives

Behavior

☐ Biting	☐ Hitting	☐ Head banging	☐ Aggression
☐ Teeth grinding	☐ Hyperactivity	☐ Sideways glancing	☐ Anxiety
☐ Cries easily	☐ Mood swings	☐ Irritability	☐ Pushes on eyes/squints
☐ Spinning	☐ Hand movements	☐ Tantrums	☐ Difficulty with transitions
☐ Obsessive interests	☐ Excessive jumping	☐ Puts hands in pants	☐ Unresponsive to name
☐ Eye rolling	☐ Inappropriate laughing/giggling		☐ Mouthing objects

Sensitivity to: □ Sound □ Touch □ Smells □ Lights □ Under-sensitivity

Speech: □ Non-verbal □ Single words □Sentences □ Conversational language

Cognition: □ Limited understanding/awareness □ Follows commands □ Normal understanding for age

Play skills: □ Appropriate □ Repetitive □ Parallel play □ Pretend/imaginative play
Interaction with others: □ Frequent □ Occasional/Some □ Rare □ None

Motor Skills □ Delayed gross motor (eg. climbing, running) □ Delayed fine motor (eg. printing)
□ Uncoordinated/clumsy □ Toe- walking

Sleep □Normal □ Difficulty falling asleep □ Frequent waking
□ Wakes crying/screaming □ Sweats during sleep □ Early waking

Digestive Health:
Loose stools or diarrhea ___ Yes ___ No Constipation ____Yes ____No
Excessive gas or bloating ___Yes ___No Bad breath ___Yes ___No
Undigested food in stools ___Yes ___No Mucous or blood in stools ____Yes ____No
Does your child produce formed stools ___Yes ___ No Stomach aches/pain ____ Yes ____No
Bowel movements: # per day _____ Pushes/lays on stomach _____Yes ____No
Is your child toilet trained ___Yes ___No Cloudy urine or sandy stool ____Yes _____ No
Color of bowel movements _____

Antibiotic History:
How many courses of antibiotics has your child received: ___ 0-5 ___5-10 ___10-15 ___15-20 ___20+
Reason for antibiotic use: ___Ear Infections ___Bronchitis/Pneumonia ___Sinus Infection
___Intestinal Infection ___Other (please explain)_____
At what age were the first antibiotics given? _____

Immune: How many colds/flus/ infections per year? _____
Difficulty recovering from illness? _____Yes _____No
History of Strep infection? _____Yes _____No
History of fungal or yeast infections? ____Yes ____No
History of high fevers? _____ Yes _____ No
Chronic nasal congestion or discharge? _____Yes _____No
Mouth breathing? _____Yes _____No
Hayfever? _____Yes _____ No
Has child had any allergy testing done?_____No ____Yes- list type_____
Any anaphylactic allergies? ____No _____Yes- list_____
Any parents or siblings with anaphylactic allergies? ____No ___Yes- list_____
_____

Home Environment:
Has child ever lived in a home greater than 50 years old? ____ No ___Yes
Has child lived in an old house undergoing renovations? ____No ____Yes
Has your child had any known exposure to lead paint or pipes ___No ___Yes
Has there been exposure to molds ___No ___Yes, explain_____
Is child exposed to pesticides or live near farms ___No ___Yes
Please list pets/animals in child`s environment _____
Is child exposed to cigarette smoke? _____Yes _____ No
Type of drinking water used _____

Mother's Pregnancy and Labor:

___High Blood Pressure ___ Seizures ___ Diabetes ___Viral Infections (e.g. flu)
____Infections treated by antibiotics-if yes for what condition _____
Rh status ___ (+ or -) Blood Type _____ Rhogam shot given during pregnancy? ___No ___Yes
Any vaccinations during pregnancy ___No ___Yes, which ones _____
Any vaccinations while breastfeeding ___No ___Yes, which ones _____
Was your child delivered _____ vaginal ___ or C-section Forceps or suction used _____
Was birth premature ___ No ____ Yes, at how many weeks _____ Is child a twin ____ No _____Yes
Any birth trauma? Describe_____
Complications/infections of baby? _____
Was epidural used? ____Yes ____No Was Pitocin/Oxytocin given during labor? ____Yes _____ No
Did Mom have silver fillings present during pregnancy? ____ No ____ Yes. If yes, how many?_____
Did Mom have any dental work done during pregnancy ___No ___Yes
Did mom have any silver fillings removed/fixed while breastfeeding child ___No ___Yes
Did mom eat fish/seafood during pregnancy? If yes give frequency _____ X per week or month
Does child have amalgam/silver fillings? ___No ___Yes Cavities? ____No ____Yes

Vaccinations:

Has child received all recommended vaccinations for their age? ____ Yes ____ No
If no, has child received any of the following (check) : ___DPT ___HIB ___Hep B ___Polio
___ MMR ___Pneumococcal ___Varicella ___Meningococcal ___Flu shot _____ H1N1
Did your child receive any vaccinations when they were sick? ___No ___Yes
Did your child have any vaccine reactions: ____Fever (circle)- Mild or High ___Rash ___Seizures
___Excessive fatigue ___Vomiting ____ Swelling at injection site ___Behavior change
____ Irritability/screaming _____Loss of eye contact/speech

Medication Usage:

List any drugs child is currently taking & reason for medication:_____
_____
Has child ever had steroid or anti-fungal drugs? ____ No ___Yes
Hospitalizations _____ No _____Yes, reason_____
Any significant injuries or trauma? List _____

Supplements:

List all supplements (vitamins, herbs, homeopathy) child is taking, **including brand and dosage:**

_____
_____
_____

Diet:

Has child been on a Gluten/Casein Free Diet? ___No ___Yes, if so how long?_____
Was any benefit observed from GF/CF diet? ____No ___Yes _____ Not sure
Have any other special diets been tried? Describe _____
Is child a picky eater? _____ Yes ____ No Does your child use a bottle or soother? ____ Yes ___No
Please describe your child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____
Protein/meat foods eaten_____
Cravings/ favorite foods _____
Appetite: □ Good □ Average □ Poor

Height _____(cm/in) Weight _____ (lb/ kg)

Family History: Check if a blood relative had any of the following and indicate relationship to child.

☐ Addiction _____	☐ Genetic Disorders _____
☐ ADD/ADHD _____	☐ Heart Disease_____
☐ Allergies_____	☐ High Blood Pressure_____
☐ Anxiety_____	☐ Kidney Disease_____
☐ Asthma_____	☐ Learning disability _____
☐ Autoimmune disease _____	☐ Bipolar Disorder_____
☐ Autism_____	☐ Diabetes _____
☐ Blood disorders_____	☐ Migraines _____
☐ Cancer_____	☐ OCD _____
☐ Celiac disease _____	☐ Multiple Sclerosis _____
☐ Crohn's/ulcerative colitis _____	☐ Schizophrenia_____
☐ Depression_____	☐ Syphilis _____
☐ Epilepsy/Seizures_____	☐ Tuberculosis_____

What are your goals in seeking treatment?

1._____

2._____

3._____

Please bring in any current supplements to the office for your first visit, as well as any blood tests or other lab results received in the last 6 months.

Thank you. I look forward to working together to help your child.