The Health Centre
INTEGRATIVE THERAPIES

Dr. Carly King, Naturopathic Doctor

The following information is confidential and will only be released with your authorization.

Patient Name: _____ Date: _____ Sex (circle one): M F

Age: _____ Grade of School: _____ Date of Birth: _____

Guardian's Name/Relationship: _____

Guardian's Name/Relationship: _____

Parents are (circle): Married Separated Divorced Common Law Other

Address: _____ City: _____ Province: _____

E-mail Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Family Medical Doctor: _____ Ph (_____)_____

Other Health Care Providers You Are Seeing:

Name: _____ Name:_____ Name:_____

Specialty _____ Specialty:_____ Specialty_____

Ph (_____)_____ Ph (_____)_____ Ph (_____)_____

HEALTH GOALS

Please list your child's health concerns in order of importance.

Health Concern	Onset Date	Previous Diagnosis? If so, what?	Diagnosis made by?
1.			
2.			
3.			
4.			
5.			

Short-term health goals? _____

Long-term health goals?_____

MEDICAL HISTORY

Current height: _____ Current Weight: _____

Has there been a ☐ gain / ☐ loss of weight recently? If so, please state how much: _____

Does your child have any known allergies or sensitivities (medicine, environmental, food, etc.)?

Allergy to	Sensitivity to	Symptoms	Last Reaction?

Please list all CURRENT medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Current Medications/Supplements	Brand	Dose	Treatment for	Start Date

Please list PAST prescription medications/natural health products.

Past Medications/Supplements	Treatment for	Start Date	End Date

Has your child ever experienced any serious conditions, illnesses, injuries, surgeries, hospitalizations?

Serious Conditions/Illnesses/Injuries/ Surgeries/Hospitalizations	Date	Is this condition still present?	Comment

Does your child suffer from?:

Ear Infections? Yes No Past If has had, how many total? _____

Frequent colds? Yes No Past If has had, how many total? _____

Strep throat? Yes No Past If has had, how many total? _____

How many times has your child been treated with antibiotics?: _____

Has your child ever had blood work done? If so, when? _____

Please check which immunizations your child has had and the approximate date of administration:

	Date		Date		Date
☐ All Scheduled		☐ Hepatitis A		☐ Flu shot	
☐ DPT		☐ Hepatitis B		☐ HPV (Gardasil)	
☐ Polio		☐ HiB		☐ Tetanus booster	
☐ MMR		☐ Chicken Pox		☐ Other	

Please indicate if any caused adverse reactions (fever, rash, ear ache, behavioural disturbances, etc.) immediately or up to a month following vaccinations: _____

PRENATAL HEALTH

Did the mother receive prenatal medical care? Yes No Unknown Age of mother at child's birth: _____

Did the mother experience any of the following during the pregnancy?

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma
☐ Other :

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs:_____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements: _____
☐ Other: _____

BIRTH HISTORY

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth:

☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps assisted ☐ Anesthesia assisted

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries _____
☐ Birth defects _____
☐ Other _____

DEVELOPMENTAL HEALTH

At what age did your child first:

Sit up _____ Crawl _____ Walk _____
Talk _____ Develop teeth _____

DIET

How is/was your infant fed?

☐ Breast fed: How long? _____

☐ Formula: Milk/soy/other: _____

If applicable, when was solid food first introduced?: _____

If applicable, which foods were first introduced: _____

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

_____

Describe a typical day's diet:

Meal	Description
Breakfast	
Lunch	
Dinner	
Snacks	
Beverages (and total quantity)	

FAMILY MEDICAL HISTORY

Please indicate if a close relative (parent, child, sibling) has had any of the following:

Condition	Family Member	Condition	Family Member
☐ Alcoholism/Addiction		☐ Eczema/Psoriasis	
☐ Allergies		☐ Heart Disease	
☐ Alzheimer's		☐ High Blood Pressure	
☐ Anxiety		☐ Kidney Disease	
☐ Arthritis		☐ Osteoporosis	
☐ Asthma		☐ Other Mental Illness	
☐ Cancer		☐ Stroke	
☐ Diabetes		☐ Thyroid condition	
☐ Depression		☐ Other	

☐ I don't know my family medical history

SLEEP

# of Hours/Night _____ Bed Time? _____ How long does it take your child to fall asleep? _____

Wake Time? _____ # of nightly wakings? _____ What for? _____

Any nightmares or night terrors? _____

ENVIRONMENT

Is the child in?: ☐ School ☐ Daycare ☐ Home care ☐ Other: _____

What are your child's favorite activities?

_____

_____

Does your child engage in regular physical activity? Y N How much, how often?:

_____
_____
_____

How much screen time (television, computer, video games) does your child get? _____ hrs a day / week

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

Do you have pets? Y N If yes, what kind? _____

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

_____
_____

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

_____
_____

PERSONAL/PSYCHOSOCIAL HISTORY

Describe your child's personality (both positive and negative aspects):

_____
_____
_____

How would you describe your child's behavior and performance at school?

_____
_____
_____

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

_____
_____
_____

Thank you for taking the time to fill out this extensive form. It helps us to understand your child as an individual so that we can work together to restore and maintain their health.

Please return this form to the Health Centre Integrative Therapies ***PRIOR TO*** *your first visit so that the assigned practitioner can assess the given information and provide you with well researched treatment options and recommendations.*

The Health Centre Team