

## Naturopathic Pediatric Health Assessment

Name of Child: \_\_\_\_\_ Age \_\_\_\_\_  M  F Date: \_\_\_\_\_

Name of Mother: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Occupation: \_\_\_\_\_

Living with  Mother  Father  Guardian \_\_\_\_\_

MAJOR HEALTH CONCERNS (IN ORDER OF IMPORTANCE)	SINCE	CAUSE
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1.) _____		
2.) _____		
3.) _____		

Is there any condition, trauma, or incident after which your child has never been totally well again?  No  Yes; If so, what?

\_\_\_\_\_

\_\_\_\_\_

SYMPTOMS (Mark "N" for current symptoms and "P" for past symptoms)

<input type="checkbox"/> Acne	<input type="checkbox"/> Measles	<input type="checkbox"/> Burning Urination	<input type="checkbox"/> Nervous
<input type="checkbox"/> Hives	<input type="checkbox"/> Tonsillitis/Strep	<input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Mumps	<input type="checkbox"/> Anemia	<input type="checkbox"/> Joint Pains
<input type="checkbox"/> Eczema	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Flat Feet
<input type="checkbox"/> Chronic Rash	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Excessive Fatigue
<input type="checkbox"/> Cradle Cap	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Unusual Fears
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Cries Easily
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thrush	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Motion/Car Sickness	<input type="checkbox"/> Sensitive to Light
<input type="checkbox"/> Rubella	<input type="checkbox"/> Frequent Urination		

### IMMUNIZATIONS

<input type="checkbox"/> Measles, Mumps, Rubella (MMR)	<input type="checkbox"/> Diphtheria, Pertussis, Tetanus (DPT)	<input type="checkbox"/> Small Pox
<input type="checkbox"/> Influenza	<input type="checkbox"/> Polio	<input type="checkbox"/> Others _____

Any reactions to any of the above?  No  Yes; If so, which ones and what type of reaction was experienced? \_\_\_\_\_

\_\_\_\_\_

### PRENATAL & BIRTH HISTORY

Fullterm, premature, late _____	Complications, if any _____
Length of labor _____	Vaginal or c-section _____
Child's birth weight _____	Anesthetics, drugs _____
Mother's age at conception _____	

**Any of the following problems for mother during the pregnancy?**

<input type="checkbox"/> Anemia	<input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> Excess Sugar Use	<input type="checkbox"/> Emotional Trauma
<input type="checkbox"/> Spotting, Bleeding, Hemorrhage	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Excess Alcohol Use	<input type="checkbox"/> Physical Trauma
<input type="checkbox"/> Morning Sickness (1 <sup>st</sup> trim)	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Recreational Drug Use	<input type="checkbox"/> Other _____
<input type="checkbox"/> Morning Sickness (2 <sup>nd</sup> , 3 <sup>rd</sup> trim)	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Abortions/Miscarriages	_____
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Preeclampsia, Eclampsia	<input type="checkbox"/> Kidney and/or Bladder Infections	

**DEVELOPMENTAL HISTORY** (if patient is less than 3 years old)

Any of the following problems during infancy?

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colic
<input type="checkbox"/> "Blue Baby"	<input type="checkbox"/> Feeding Difficulties	<input type="checkbox"/> Rashes	<input type="checkbox"/> Injuries
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fever	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____

Was child breastfed?  No  Yes; for how long? \_\_\_\_\_ Any problems? \_\_\_\_\_

Was child put on formula?  No  Yes; what kind? \_\_\_\_\_ Any problems? \_\_\_\_\_

Age at which solid foods introduced \_\_\_\_\_ Food introduced \_\_\_\_\_

**Please indicate if there were any problems with the following and age when activity first started:**

**AGE**

Holding head up while on stomach \_\_\_\_\_

Rolling from front to back and back to front \_\_\_\_\_

Sitting with and without support \_\_\_\_\_

Crawling \_\_\_\_\_

Teething \_\_\_\_\_

Talking (first word, combination of words, sentences) \_\_\_\_\_

Walking with and without support \_\_\_\_\_

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

Any particular habits (thumb sucking, nail biting, head banging, rocking) \_\_\_\_\_

Were there any nightmares, terrors, or sleepwalking? \_\_\_\_\_

**DENTAL HISTORY**

Last Dental Exam: \_\_\_\_\_

Describe any dental work done: \_\_\_\_\_

What is the oral hygiene practice of the child? \_\_\_\_\_

Is your child's toothpaste fluoridated?  No  Yes

Does your child have bleeding gums?  No  Yes

**VISION HISTORY**

Last Vision Exam: \_\_\_\_\_

Describe any vision problems: \_\_\_\_\_

**FAMILY HISTORY** (Indicate maternal with "M" and paternal with "P")

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Allergies/Hay fever	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Thyroid (hyper/hypo)	

**OVERALL HEALTH**

**Digestion**

<input type="checkbox"/> Weak appetite	<input type="checkbox"/> Bloating
<input type="checkbox"/> Strong appetite	<input type="checkbox"/> Gas
<input type="checkbox"/> Body/breath odor	<input type="checkbox"/> Number of bowel movements a day
<input type="checkbox"/> Excess gas	Color _____
<input type="checkbox"/> Abdominal pains	<input type="checkbox"/> Formed
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Soft
<input type="checkbox"/> Canker sores	

Other comments: \_\_\_\_\_

**Sleep**

<input type="checkbox"/> Light	<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Deep	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Lacking	<input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> Excess	<input type="checkbox"/> Nightmares

Position: \_\_\_\_\_

Other comments: \_\_\_\_\_

**Immune System**

<input type="checkbox"/> Good	<input type="checkbox"/> Sore throats
<input type="checkbox"/> Poor	<input type="checkbox"/> High fevers
<input type="checkbox"/> Frequent colds/flu	<input type="checkbox"/> Chronic coughs

Other comments: \_\_\_\_\_

**Mental Emotional Disposition**

How does your child express the following emotions?

Anger \_\_\_\_\_

Sadness \_\_\_\_\_

Anxiety \_\_\_\_\_

Happiness \_\_\_\_\_

Fear \_\_\_\_\_

What fears does your child have \_\_\_\_\_

List major experiences of grief/loss in your child's life and how your child has coped with them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Dates: \_\_\_\_\_

**Food Plan Instructions:**

- Please record, in honesty, what you eat for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food is eaten (“white bread” or “whole wheat bread”), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals do you generally eat each day? One Two Three More than three

How often do you skip meals? Never Once or twice a month Once a week More than once a week

Where do you usually buy your food? \_\_\_\_\_

Who cooks the food you eat? \_\_\_\_\_

List the foods you exclude from your diet and why: \_\_\_\_\_

List any foods you crave, regardless of their nutritional value: \_\_\_\_\_

List any foods to which you are allergic to or have a bad reaction to and how you react: \_\_\_\_\_

Are you thirsty?  No  Yes Amount of plain water you drink each day \_\_\_\_\_

What type of water do you drink? Distilled water Filtered Spring Well Deionized Tap

At what temperature do you prefer to drink liquids?  Hot  Cold  Room temp