



Inspired Health Naturopathic Clinic

..... O k # , BC V9# T5 Phone: (250) -

Dr. Trevorrow and her staff are delighted to welcome your family to our clinic! Please fill out the following personal information and health history to give us the best picture possible of your child's concerns.

Personal Information (please print):

Child's Name: _____ Date of First Visit: _____

Parent(s) Name (s): _____

Address: _____

City: _____ Province/State: _____ Postal code: _____

Phone (home): _____ (work-parent): _____

Alternate phone: _____ BC Health Care #: _____

Email address: _____ May we correspond with you by email? Y N

Child's birth date: _____ Gender: M F

Are there other family members seen here? _____

Emergency contact person: _____ Work phone no.: _____

Relationship to patient: _____ Home phone no.: _____

How did you hear about our clinic? _____

Note: Please bring a recent picture of your child that we may keep plus a baby picture that we may look at and return—thanks!

Child's Medical Information:

Current General Practitioner (MD): _____ none at present

GP address/phone: _____

Are you seeing a pediatrician or other medical specialist? Yes _____ No _____

If yes, for what reason? _____

Name/address/phone of specialist (if care is ongoing):

Therapist(s): (speech/occupational/physical/nutritionist/counsellor):

Name	Type of therapist	Phone	City	Hours/week

Diagnoses or explanation(s) given to you about your child (Date of diagnosis: ____/____/____)
(m/d/y):

Other problems to be addressed: _____

Siblings:

Name:	Gender (circle one):	Birth date: (month)	(day)	(year)
	M/F			
	M/F			
	M/F			
	M/F			

What questions do you have that you would like answered? _____

What kind of help would you like to be provided? _____

I hereby consent to treatment by the practitioners of Inspired Health Clinic. I understand that I am responsible for any treatment and pharmacy costs at the time of my visit. I also understand that I am responsible for paying a \$25.00 fee if I do not give 24 hours' notice of cancellation.

Signature: _____ Today's date: _____

(Parent or guardian if a minor)

Prenatal History:

Maternal age at delivery: _____ years
Illnesses during pregnancy:
Medication(s) during pregnancy:
Other complications during pregnancy (if they occurred):
Complications during labour and delivery:
Mode of delivery (Caesarean/vaginal)? If C-section, were you told why?
If vaginal delivery, did you have forceps/vacuum? Were you told why?
Medications during labour/delivery?
Was your baby _____full-term _____premature (check one). How many weeks?
Were there complications after delivery? And if so, what were they?
Were there medications given to child while he/she was in the hospital?

Dietary/Nutritional History

Breast-fed? Yes _____ No _____ If yes, how long? _____

If bottle-fed, what type/brand of formula? _____

Begun at what age? _____ For how long? _____

First food introduction at what age? _____ What were they? _____

Did you give whole milk? Yes _____ No _____ If yes, begun at what age? _____

Known allergies to food? (Please list): _____

Suspected sensitivities to foods? (Please list): _____

Food cravings? (please list): _____

Foods my child eats (Place in appropriate column):

Food	Daily	3-5x/week	1-3x/week	Never/almost never	Used to eat a lot but no longer does
Cookies:					
Candy:					
Sweet foods:					
Caffeinated drinks (coke, tea etc.)					
Chocolate:					
Milk: Whole:					
2%:					
1%:					
Skim:					
Cheese:					
Ice Cream:					
Salty foods:					
Meat:					
Pasta:					
Bread: White:					
Whole wheat:					
Other:					

Have you tried any special diets? Please indicate below:

now	past	Diets	Very good	Good	None	bad	Very bad	Bad then good	Comments
		Gluten free							
		Casein free							
		Yeast free							
		Feingold							
		Food avoidance							
		Other:							

Any odd/strange GI symptoms that you notice often (ie. Gas/bloating/diarrhea/constipation etc)?

Environmental History

PLEASE CHECK (✓) THE BEST ANSWER(S) TO THE FOLLOWING QUESTIONS:
Location of home: ___City ___Suburban ___Wooded ___Farm ___ Other (describe):
Water: ___Municipal ___ Well Water purification ___Yes ___No? If yes, please describe:
Type of heat: ___Electric baseboard ___natural gas ___heat pump ___other. If other, please describe:
Does your home have a lot of: ___dust ___moulds ___down/feather teams (pillows, upholstery stuffed animals). If yes, please give details:
In your child's bedroom, is the bedding ___synthetic ___down/feather? Is there a mattress cover? ___Yes ___No
Is the floor ___wall to wall carpet ___wood alone ___wood with area rug ___other? If other, please describe:
What window covering(s) do they have: ___shades ___blinds ___thin curtains ___heavy curtains ___valence ___other? If other, please describe:
Please list other items in child's bedroom including furniture, toys, stuffed animals:

Flooring in other rooms—please describe the flooring in
<ul style="list-style-type: none"> • The child's bathroom
<ul style="list-style-type: none"> • The living room?
<ul style="list-style-type: none"> • The family/play room?
Is your child sensitive to or bothered by any of the following? Please check all that apply and give specific products if possible:
___ perfumes/cosmetics?
___ cleaning products?
___ soaps?
___ detergents?
___ dust?
___ mould(s)?
___ pollens/grasses?
___ animal(s)?
___ gasoline?
___ other things?
Please list known allergies for your child:

Developmental History

Please list age when following skills were mastered and any problems associated with these skills:

First words: (age ___)
Phrases or sentences: (Age: ___)
Pulling to stand: (Age: ___)
Walking: (Age: ___)
Sitting up: (Age: ___)
Crawling: (Age: ___)
Running: (Age: ___)
Walking up/down stairs without help: (Age: ___)
Jumping: (Age: ___)

Learned to pedal: (Age:___)
Rode 2-wheel bike: (Age:___)
Put on clothing: (Age:___)
Tied shoes: (Age:___)

Medical History:

Current medications: please list any prescription medications (from your doctor) or over the counter medications (such as aspirin, cold medicines, antacids) your child is taking:

- 1)_____ 3)_____
- 2)_____ 4)_____

Please list any supplements (vitamins/minerals/herbs etc) you are giving your child:

- 1)_____ 3)_____
- 2)_____ 4)_____
- 5)_____ 6)_____

Has your child ever taken antibiotics? YES NO (circle one). If yes, about how many times has he or she taken antibiotics?_____ If yes, do you remember which ones were taken?_____

Have you tried any supplements in the past which didn't seem to help? If so, what were they?_____

Major injuries – Please describe and give dates:

INJURY	DATE(S)	RESULTS

Major surgeries (i.e. tonsils, ear tubes, etc.) – Please describe and give dates:

SURGERY	DATE(S)	RESULTS

Illnesses-please list dates and any complications (if any):

ILLNESS	DATE(S)	COMPLICATIONS (if any)
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Chicken pox		
Mononucleosis		
Thrush		
Other: (please list): _____ _____ _____ _____		

Immunizations

Has your child has the following immunizations? (Note: this is the regular BC schedule listed below). If so, did they have a reaction to any particular one? If yes, check the box that applies.

Note: 'bowel' refers to any bowel symptoms, i.e. diarrhea. 'Swelling' refers to swelling at the site of injection.

Diphtheria/tetanus/ acellular pertussis / IPV/Hib	Yes/No	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
2 months								
4 months								
6 months								
18 months								
4-6 years (w/out Hib)								
Grade 9 (Tdap)								
Hepatitis B								
2 months								
4 months								
6 months								

Grade 6 (2 doses)								
Pneumococcal conjugate								
6 months								
1 year								
18 months								
Meningococcal C conjugate								
2 months								
1 year								
Grade 6								
Influenza								
6 months								
1 year								
MMR								
1 year								
18 months								
Varicella								
1 year								
4-6 years								
Grade 6								

Family History:

Please list any allergies, major illness, genetic diseases, or problems for each of the following family members of your child:
Mother:
Father:
Siblings:
Maternal grandparents:
Paternal grandparents:
Others:

Symptoms

Please check (✓) any symptoms that your child may demonstrate and the frequency/intensity:

Description	Mild	Moderate	Severe	Duration	Unique details
Inability to concentrate/focus					
Always fidgety in his/her seat					
Acts as if 'driven by a motor'					
Irritability/tantrums					
Aggressiveness (hitting, biting, kicking others)					
Impulsively acts					
Problems with social interactions					
Poor co-ordination					
Problems with buttons, ties, snaps or zippers					
Runs away in shopping malls or similar places					
Often appears to be 'not listening'					
Low self-esteem					
Sensitive to crowds					
Difficulty falling asleep					
Difficulty waking					
Bed wetting/soiling					
Day time wetting/soiling					
Headaches often					
tics					
Dark circles/puffiness under eyes					
Eye discharge					
Sensitivity to bright lights					
Nasal congestion (chronic)					
Nose bleeds					
Acute sense of smell					
Earaches					
Sensitive to loud noises					
Sore throats					
Cough					
Description	Mild	Moderate	Severe	Duration	Unique details
Diarrhea					
Constipation					
Bloating after meals					
Gas					
Stomach ache					
Refusal to eat/will only eat certain foods					
Food craving					
Grinding teeth					

Muscle cramping or 'growing pains'					
Itchy patches on skin					
Hives					
Sensitive to texture of clothes					
Any other unique symptoms you see:					

Thank you for taking the time to fill out this form.

~Dr. Marianne Trevorrow, ND