Back to Health Wellness Centre
New Patient - Pediatric Questionnaire Ages 0-2

General Information

NOTE: IF A FIELD DOES NOT APPLY PLEASE ANSWER "N/A" or NOT APPLICABLE

Name of Parent

Email

Home/Cell #

Work #

Address

City

Postal Code

Name of Child

Address (if different from parent)

Date of Birth

Age

Sex

During pregnancy, were you on any medication? Did you smoke or consume any alcoholic beverages?

Did you have any back pain?

Approximately, how long was labour?

Were you physically ill? (Colds, flu, allergies, German measles, etc.) if so please list

Regarding Labour:

Was it chemically induced?

Doctor assisted

Was a C-section performed?

Were forceps used?

Did the doctor have his hands on the infant?

How long was the labor?

How severe was your pain/discomfort during labour and delivery?

Were there any complications before or during delivery? (if yes, please explain)

Was the baby premature? (If so, what was his/her age and weight)

Has your child suffered any health problems:

Please select any that apply:

- ☐ Headaches
- ☐ Sleeping disorders
- ☐ Irritability
- ☐ Flu
- ☐ Diarrhea
- ☐ Rashes
- ☐ Digestive Problems
- ☐ Allergies
- ☐ Breathing Problems
- ☐ Hyperactivity
- ☐ Bloody Noses
- ☐ Constipation
- ☐ Milk/Lactose Intolerance
- ☐ Ear problems
- ☐ Fatigue
- ☐ Frequent Colds
- ☐ Meningitis
- ☐ Colic
- ☐ Bed Wetting

Other:

Regarding Your Child Today

Is your child accident-prone?

If yes, please describe:

Has the child had any falls down steps?

If yes, please describe:

Has your child ever fallen from heights?

If yes, please describe:

Has your child been involved in a motor vehicle accident?

If yes, please describe:

Has your child ever been hospitalized or had surgery?

If yes, please describe:

Does your child suffer from allergies/sensitivities (environmental, foods, drugs, etc.)?

If yes, please describe:

Has your child received all childhood vaccinations?

Does your child get regular flu vaccinations?

Has your child had any complications from any vaccinations?

Date of last Annual Physical Exam/Blood Test

Date and Reason for last Antibiotic Use*

DIET AND LIFESTYLE

Many of the following questions are for our naturopath’s required information

Does your child eat or use any of the following?

- ☐ Aluminum pans
- ☐ Air fresheners
- ☐ Fast foods
- ☐ Artificial sweeteners
- ☐ Plastic tupperware
- ☐ Scented body products
- ☐ Refined/processed food
- ☐ Luncheon meats
- ☐ Microwave
- ☐ Fried foods
- ☐ Candy
- ☐ Margerine

Does your child have any dietary restrictions? (Vegetarian, religious, etc.)

How does your child eat their meals? (check all that apply)

- ☐ With family around the table
- ☐ On the run
- ☐ Fast food
- ☐ In front of the TV
- ☐ Restaurant

How often does your child eat at a restaurant?

How often does your child eat fast food?

Please describe what your child typically eat in one day:

Breakfast

Lunch

Dinner

Snacks

Food Likes/Cravings

Water (cups/day)

Milk (cups/day)

Other

How many hours does your child sleep daily?

Does your child have problems sleeping?

Does your child wake feeling rested?

Does your child have a bowel movement daily?

Does your child suffer from headaches?

If yes, please describe:

Has your child ever had any broken bones or sprain injuries?

If yes, please describe:

Is your child on any medication?

If yes, please list type/dosage:

Has your child had a scoliosis examination by an approved scoliosis determination clinic?

If yes, please describe:

Is your child hyperactive?

If yes, please describe:

Have learning disorders?

If yes, please describe:

Poor posture?

If yes, please describe:

Does your child have any problems associating with friends?

If yes, please describe:

Is your child nervous or has anyone suggested that your child was nervous?

If yes, please describe:

Does your child have asthma?

If yes, please describe:

If you could improve one aspect of your child’s health or behaviour, what would it be?

Thank you for completing the New Patient - Pediatric Questionnaire. Please choose one of the following methods to send this form to the Back to Health Wellness Centre:

Email
Choose "File" menu above and select "Attach to Email". Click on "Attach" on right hand side. Send to reception@back2health4you.com

Print and Fax
Choose "File" menu above and select "Print"
Fax to 613-237-3100