ImmuneND Nutritional and Complementary therapies for Immune and related disorders

Children's Confidential Health Questionnaire (Under 12 Years old)

Dear Parents: Please complete this questionnaire on behalf of your child. Please print. Thank you.

NAME _____ DATE _____ PHONE _____

AGE _____ HEIGHT _____ WEIGHT _____ DATE OF BIRTH _____

What is the chief concern about your child's health? _____

What do you think is causing your child's health problems?

Is your child on any medication?

Has your child lost any days at school because of health concerns recently?

How is your child's sleep quality (length of sleep, early riser etc) _____

Has your child had the usual vaccinations? ____ Any adverse reactions?

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Please indicate which of the following your child has had:

	Yes/no	Age	Severity
Roseola	_____	___	_____
Rubella	_____	___	_____
Measles	_____	___	_____
Mumps	_____	___	_____
Chicken pox	_____	___	_____
Scarlet fever	_____	___	_____
Pertussis	_____	___	_____
Strep throat	_____	___	_____
Impetigo	_____	___	_____
Mononucleosis	_____	___	_____

Hospitalizations?

_____

_____

Surgery?

_____

_____

Major accidents or illnesses?

_____

_____

Seizures?

_____

_____

Please circle any of the following that are in your family?

Allergies	Cancer	Heart disease	Celiac	Asthma
Alcoholism	Cataracts	Hyperactivity	Ulcers	Mental illness
Arthritis	Bowel disease	Kidney disease	Epilepsy	Tuberculosis
Diabetes	Depression	Multiple sclerosis		

How was the mother's health during pregnancy?

_____

_____

_____

What vitamins / supplements were taken during pregnancy?

_____

_____

_____

Any medications during pregnancy?

_____

_____

Did the mother drink alcohol or smoke during pregnancy? _____

Mother's diet during pregnancy? Poor_____ fair _____ good _____ excellent _____

How was the mother's emotional state in pregnancy? Excellent_____ stable ____ stressed

_____

_____

Any complications at birth? _____

Was your child breast-fed? _____ For how long? _____

What were your child's first foods? _____

_____

_____

_____

What are your child's favorite foods currently? _____

_____

_____

What is a typical

Breakfast

_____

_____

_____

Lunch

_____

_____

_____

Supper

_____

_____

_____

What vitamins or supplements does your child take?

_____

_____

_____

Has your child's physical development been

Slower than average _____ average _____ faster than average _____

Has your child's emotional development been
Slower than average _____ average _____ faster than average _____

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Consent to Treatment of a Minor

Patient Name _____ Age _____

I authorize Scott Woodworth, ND, and such other Naturopathic practitioners and assistants as she may select or approve, to examine and administer Naturopathic care and treatment to:

_____ whose relationship to me is _____

The consent is modified as follows:

_____

_____

My name, address and telephone number or that of another contact person for the patient is as follows:

_____

_____

_____

Phone number: _____

Dated this ____ day of _____, 20____.

_____ _____

Parent or Guardian of Minor Signature