BALANCE
INTEGRATED HEALTHCARE

Naturopathic Pediatric Health History

(0 -12 years of age)

To be completed by the parent/guardian. An accurate health history is important to ensure that it is safe for your child to receive treatment. If the health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date of Birth: _____ Gender: _____

Address: _____
Number Street Suite City Province Postal Code

Mother's Name _____ Father's Name _____

Tel (home): _____ Tel (work): _____ Cell: _____ E-mail _____

Physician/Pediatrician's Name: _____ Tel: _____

Physician's Address: _____
Number Street Suite City Province Postal Code

In Emergency Notify: _____ Relationship: _____ Tel: _____

Date of last visit to physician or health practitioner: _____ How did you hear about us? _____

What is/are you child's chief health concern(s)? _____

_____

Medications and Supplements (over-the-counter and prescription) _____

_____

How many times and for what reasons has your child been treated with antibiotics?

_____

Prenatal History

Mother's age at time of birth _____ Father's age at time of birth _____

Mother's health during preganancy _____

Please check all that apply

_____ Alcohol / Drug/ Tobacco
_____ Bleeding
_____ Depression
_____ Diabetes
_____ High Blood Pressure
_____ Nausea
_____ Physical / Emotional Trauma
_____ Stress
_____ Travel
_____ Thyroid Condition
_____ Weight Gain (how much)
_____ Xrays / other tests

Over-the-counter or Prescription drugs during pregnancy: _____

Supplements during pregnacy: _____

Were there any problems conceiving? _____

Did Mom have any food cravings? _____

Were there any foods that Mom could not tolerate? _____

Birth History

Vaginal Birth _____ C-Section _____

Term: Full _____ Premature _____ Late _____

Labor: Spontaneous _____ Induced _____

Complications at Birth _____

Interventions at Birth (e.g. anesthesia, epidural, episiotomy, forceps, vacuum, other) _____

_____

Birth Weight _____ Birth Length _____

General Information

Breast Fed? _____ For how long? _____ Formula? _____ What kind? _____

Solid Food Introduction:

Age	Food	Reactions (if any)

Is the baby / child currently exposed to

☐ Cigarettes ☐ Chemicals ☐ Molds ☐ New Carpet

Surgeries and Hospitalizations (include dates and details)

_____

_____

_____

Medical History

Please check all that apply:

- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Ear Infection (s)
- ☐ Strep Throat
- ☐ Pneumonia
- ☐ Frequent Colds
- ☐ Chickenpox
- ☐ Tonsillitis
- ☐ Scarlet Fever

Immunizations

Vaccine	Adverse Reaction
Measles, Mumps, Rubella (MMR)	_____
Diptheria, Pertussis, Tetanus	_____
Polio	_____
Influenza (“the flu”)	_____
Hepatitis	_____
Other: _____	_____

Please circle if you child is currently experiencing (”C”) or has experienced in the past (”P”) any of the following:

- ☐ Asthma
- ☐ Cough/Wheeze
- ☐ Frequent Infections
- ☐ Earache
- ☐ Colic
- ☐ Nosebleeds
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Heart Murmur
- ☐ Anemia
- ☐ Acne
- ☐ Eczema
- ☐ Cradle Cap
- ☐ Jaundice
- ☐ Thrush
- ☐ Warts
- ☐ Epilepsy/Seizures
- ☐ High Fever
- ☐ Bed Wetting
- ☐ Fatigue
- ☐ Insomia
- ☐ Dizzy Spells
- ☐ Headaches
- ☐ Hyperactivity
- ☐ Moodiness
- ☐ Learning Difficulties
- ☐ Unsual Fears
- ☐ Depression

Food, environmental, and / or pet allergies _____

_____

_____

Describe your child’s temperament. _____

_____

_____

_____

Child’s favorite activities / hobbies _____

_____

Family History Health History

Please check relevant areas for blood relatives.

- ☐ Asthma
- ☐ Arthritis
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Eczema
- ☐ Epilepsy
- ☐ Gout
- ☐ Hay fever allergies
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Mental Disorders
- ☐ Obesity
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tubercolosis
- ☐ Thyroid Problems

Diet

Please describe a typical day's diet for your child:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Food dislikes _____

Does the child have any dietary restrictions?

_____

Is there any additional information that you would like to add?

_____

Signature _____ Date _____

Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.

BALANCE
INTEGRATED HEALTHCARE

Consent Information

We would like your consent. We want you to understand the services we hope to provide to you, the cost involved and what we do with personal information we obtain from you. If you have any questions on any of the following information, please do not hesitate to ask.

Consent for Treatment
I have read and understood all of the associated forms, answered them truthfully and to the best of my knowledge and fully consent to treatment at Balance Integrated Healthcare. I understand that there is a 12-hour cancellation policy and if I fail to notify the clinic, then I may be charged for my session.

Consent for the Cost of our Services
I understand the costs of the services that I am being provided at Balance Integrated Healthcare.

Consent for Personal Information
I understand that in order to provide me with the services I am seeking, Balance Integrated Healthcare will collect some personal information about me (e.g. home telephone number, address, emergency contacts).

I have reviewed Balance Integrated Healthcare's privacy policy about the collection, use and disclosure of personal information, the steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given the chance to ask any questions I have about the privacy policy and they have been answered to my satisfaction.

I understand that, as explained in Balance Integrated Healthcare's Privacy Policy, there are some rare exceptions to these commitments.

I understand that if I do not check off the following boxes I will receive the following:

- ☐ Please **DO NOT** send me the monthly Balance Integrated Healthcare *Healthy Insights* newsletter (find out about a new health topic every month) written by one of the practitioners at Balance Integrated Healthcare. (email required).

- ☐ I would **NOT** like to receive email/mail notices of promotions and special offers from Balance Integrated Healthcare (helps you stay on top of all the events at Balance Integrated Healthcare including upcoming seminars/workshops and newly acquired services!)

I hereby agree to Balance Integrated Healthcare collecting, using and disclosing personal information about me only with my expressed written authorization.

Signature | Name (please print) | Date

Notes (office use only)