Thornhill Naturopathic HEALTH CLINIC

12A Centre Street
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www.thornhilllnaturopathic.ca

Telephone: 647-799-1078
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HEALTH ASSESSMENT QUESTIONNAIRE - CHILDREN

This is a confidential health assessment questionnaire which is designed to provide insight into your child's health and behaviour and lifestyle. The following questions will assist in providing the best possible care for your child and in understanding the factors that may be playing a role in your child's health.

The following questionnaire is **not** designed to give a medical diagnosis. It will identify current strengths of your child's health, any risk factors that might be present, and it will be used by the Naturopathic Doctor to highlight recommendations that you may want to consider.

This questionnaire will take about 45 minutes to complete. The length of time that you take to answer the questions is completely up to you and has no bearing on the results.

General Guidelines to follow when filling out the Questionnaire :

- Select the answer that is best suited to each question
- Read all questions carefully prior to answering
- Write in any response that is not provided on the questionnaire (e.g. if you do other exercises)

The Naturopathic Assessment for children is divided into nine categories:

A.	General Information	B.	Parent's Health during Pregnancy
C.	Family History and Information	D.	First Few Years of your Child's Life
E.	Past and Present Health Concerns	F.	General Information on Diet
G.	A Typical Day for your Child	H.	Understanding your Child's Patterns of Behaviour
I.	Review of Physical Systems		

Please circle the response that is correct or fill in the blanks.

A. GENERAL INFORMATION

Current Date: _____/_____/_____
Day/Month/Year

Child's Name: _____

Nick Name: _____

Date of Birth: _____/_____/_____ Age: _____ Birth order: _____
Day/Month/Year

Number of Siblings: _____ Ages of other siblings: _____

Mother's name: _____Father's name: _____

Occupation: _____Occupation: _____

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B. PARENT'S HEALTH DURING PREGNANCY

Age of mother at time of birth: _____ Age of father: _____

Did the mother work outside the home while pregnant: YES NO If yes, until when? _____

Comment on the mother's health during pregnancy (e.g. nausea/vomiting, diabetes, bleeding etc.)

_____

_____

Comment on the father's health during conception: _____

_____

_____

Please list the quantity of the following used by the mother during pregnancy?

Substance	Amt/ week	Substance	Amt/ week	Substance	Amt/ week
coffee		tea		water	
alcohol / beer / wine		drugs (prescription or recreational		iron / vitamin supplements	
cigarettes		fruit		vegetables	
processed / fast food		sugar / chocolate		dairy / cheese	
bread / grains		meat / fish		nuts / seeds	

List any food cravings during pregnancy: _____

_____

Duration of pregnancy: _____ How many other pregnancies: _____

Type of delivery: _____ Number of hours in labour: _____

Please circle any of the following that were used during the birth process:

epidural ☐ ☐ forceps ☐ anaesthesia ☐ sedation other _____

Comment on the mother's health after pregnancy: _____

_____

Comment on the family environment at home:_____

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C. FAMILY HISTORY and INFORMATION

Please outline the health status of the following:

	Present Health Status	Previous illnesses, injuries
Mother		
Father		
Siblings		
Grandparent(s)		
Other close relatives		

LIFE CHANGE EVENTS

Please circle any of the following that your family has experienced since your child's birth or just prior to your child's current health concern(s):

death (family, close friend) ☐ new baby ☐ job loss ☐ divorce ☐

marital separation ☐ new family dynamic ☐ retirement ☐ change of residence ☐

parent's return to work ☐ increased family stress ☐ new school for child ☐

sickness of family member

Comment on any events that you feel may have affected your child: _____

_____

_____

INFORMATION ON YOUR HOME

Do you live in the country, suburbs or the city? _____

Are there any power lines / power stations etc. near your home? _____

Age of the home: _____ How is your home heated? _____

Type of flooring used in the home: _____

Any recent renovations *(what type and when):* _____

_____

_____

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D. FIRST FEW YEARS OF YOUR CHILD'S LIFE

Comment on his / her health at birth (please list any complications): _____

_____

Apgar score? _____ Onset of respiration: _____

Was he/she breast fed? YES ○ NO ○ If yes, for how many months? _____

If yes, what was the mother's experience with breast feeding: _____

Type of formulae used (if any): _____

Comment on your child's behaviour during the first six months of life for the points listed below:

Crying: _____

Sleeping: _____

Urination: _____

Defecation: _____

Comment on your child's health in his / her first year of life: _____

Please list at what AGE that your child was with respect to the following:

Rolled over on their own: _____

Sat up on their own: _____

Started crawling: _____# of months he/she crawled: _____

Stood with support: _____ Stood on their own: _____

Started walking: _____ Walked up/down stairs: _____

Said their first word: _____ Able to put 2-3 words together: _____

Spoke sentences: _____ Started to count/recite alphabet: _____

Started teething: _____ Any problems with teeth? _____

Started eating solid food: _____ Is he/she a picky eater? _____

Food likes: _____ Food dislikes: _____

Started toilet training: _____ Completed toilet training: _____

Any problems during toilet training: _____

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HEIGHT AND WEIGHT DEVELOPMENT:

Height at birth: _____ feet _____ ins. / _____ cms. **Weight at birth**: _____ lbs / kg

Height at 1 year: _____ feet _____ ins. / _____ cms **Weight at 1 year**: _____ lbs / kg

Height at 2 years: _____ feet _____ ins. / _____ cms **Weight at 2 years:** _____ lbs / kg

Height at 5 years: _____ feet _____ ins. / _____ cms **Weight at 5 years:** _____ lbs / kg

Height at 10 years: _____ feet _____ ins. / _____ cms **Weight at 10 years:** _____ lbs / kg

Please list any period of rapid weight loss or gain (and describe): _____

_____

Describe any developmental concerns: _____

_____

E. PAST AND PRESENT HEALTH CONCERNS

Childhood Illnesses / Accidents / Major Fall or Injuries *(please list including duration and treatment(s):*

_____

_____

Operations / Hospitalizations / Medications *(please list including duration and treatment(s):*

_____

_____

Please circle the following immunizations or vaccines that your child has had:

Diphtheria ☐ Pertussis ☐ Tetanus ☐ Hib ☐ Polio ☐ MMR ☐

Has your child had any reactions? _____

_____

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Please circle any of the following symptoms that your child has displayed:

eczema ☐	rashes on face ☐	roseola ☐	ear infections ☐	whooping cough ☐
croup ☐	food intolerances ☐	constipation ☐	diarrhea ☐	reaction to insect bites ☐
fevers ☐	frequent colds ☐	antibiotic use ☐	stuttering ☐	temper tantrums ☐
measles ☐	chicken pox ☐	convulsions ☐	clumsy ☐	excessive crying ☐
shyness ☐	easy bruising ☐	nose picking ☐	bed wetting ☐	need to be held ☐
asthma ☐	hitting ☐	biting ☐	allergies: _____	

Your child's health concerns	When did they start?	Who noticed the concern?	Constant or intermittent?	Comments (impact to the family, event that may have initiated concern)

F. GENERAL INFORMATION on DIET

On a scale of 1 (low) - 10 (high) how would you rate your child's diet? _____

Why: _____

_____

On average how many meals are eaten a day ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ + 5

What is the largest meal?: ○ breakfast ○ lunch ○ dinner What time is the last meal? _____

List any supplements / prescription medications that your child is taking: _____

_____

_____

Are there any foods that he/she craves? _____

_____

Are there any foods that he/she avoids? _____

_____

_____

Is any specific diet regime followed? ___ vegetarian ___ vegan ___ other _____

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Please list what your child would typically have for:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Other information on his/her nutrition: _____

_____

G. A TYPICAL DAY FOR YOUR CHILD

During a typical day list the amount of time your child spends doing the following activities:
Note: the total time will probably add up to more than 24 hours due to the nature of the question.

Activity	Time (hours)	Activity	Time (hours)
Sleeping during the night		Sleeping during the day	
Eating		Playing outside	
Reading / Arts and Crafts		Exercising	
Watching television		On the computer i.e games, internet	
Playing on their own (not television)		Playing with others	
Time spent with mother / father		Time spent with caregiver (not parents)	

Describe a typical weekday routine for your child. _____

_____

Describe a typical weekend routine for your child. _____

_____

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H. UNDERSTANDING YOUR CHILD'S PATTERNS OF BEHAVIOUR:

List the primary caregiver(s) for your child: _____

Bedtime routine: _____

Sleep patterns / quality: _____

Dreams or nightmares: _____

Interaction with siblings / other children: _____

Is your child more comfortable with men or women? _____

Behaviour around strangers: _____

Fears / Anxieties: _____

Discipline methods used at home: _____

Your child's response to discipline: _____

How did / does your child soothe himself/herself: _____

Age at which your child first attended day-care / nursery school: _____

Adjustment to day-care / nursery school: _____

Academic performance at school: _____

Any learning / comprehension concerns: _____

_____

Social behaviour at school: _____

Sports / exercise your child enjoys: _____

Activity level: _____

Favourite activities: _____

_____

How does your child handle new environments / situations? _____

_____

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Describe any behavioural concerns: _____

_____

What characteristics are unique about your child: _____

_____

Use of seat belt / car seat: _____

Use of helmet / safety equipment when playing: _____

Pets at home (type and number): _____

Does anyone smoke in the home? If yes please specify: _____

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I. REVIEW OF PHYSICAL SYSTEMS

Comment on the health history of the following systems.

System	Past concern?	Present concern?	Comments
Skin			
Head			
Mouth			
Eyes			
Ears			
Vascular system			
Nervous system			
Digestive system			
Urinary system			
Respiratory system			
Muscles and bones			
Endocrine system			

Please include any other information that you feel would be helpful in understanding and treating your child?

Thank you for completing this questionnaire.