Pediatric Health Profile vitalhealth

All information is confidential. Please fill out as thoroughly as possible. Holistic health care is most effective when the doctor has an in-depth understanding of your child's health history. **Please set aside at least 20 minutes to fill out this form.** Please put a question mark next to any questions you are unsure about. Thank you very much for your time!

Name ______________________ Date of Birth ______________ Today's Date ______________

General Information

What are your primary health concerns/reasons for visit?	If applicable, please list prior approaches related to your concerns:		
	Prior diagnoses	Prior labs/imaging	Prior treatments

Parents: Please fill out the following section considering your expectations as parents and motivation to make changes for your child's health.

What expectations do you have of your **first visit** experience?

What **long-term** expectations do you have from working with me?

To what extent are you open to changes in lifestyle habits to address your child's concerns? *Circle.* (least open) **1 2 3 4 5** (most open)

Are there any lifestyle factors (sleep, stress, family dynamics) that you think may be contributing to your child's health issues?

Do you have any idea of what triggered or is causing your child's symptoms?

Are you familiar with a naturopathic approach or have you or your child ever seen a naturopathic doctor, chiropractor, acupuncturist, or other alternative health care practitioner?

If there are specific wellness therapies/programs you are interested in, please check them here:
◊ Nutritional counseling ◊ Herbal Medicine ◊ Homeopathy ◊ Exercise therapy ◊ Detoxification Program
◊ Disease prevention ◊ Emotional wellness ◊ Other

If supplements are recommended, what are your preferences? *(√ all that apply and cross out those you are definitely not interested in))*
◊No preference ◊Powder ◊Liquid ◊Capsule/Tablet ◊Tea ◊Tincture (alcohol/glycerine based) ◊I prefer for my child not to use supplements

Health Profile page two

Medications and Supplements

Current Prescriptions, Over the Counter Meds, & Supplements (include oral, topical, and suppositories)

Name (Include brand for supplements)	Dose&Frequency (ex. 500mg 3x/day)	Start date (approximate)	Reason for taking	Has it helped?	Who prescribed? (self or Dr. name)

Don't forget to include topical treatments, herbs, homeopathics & commonly used things like aspirin, pain-relievers, multivitamins.

Has you child used any of the following for an extended period? *Circle.* Antibiotics Cortisone/Steroids Laxatives Decongestants

Past Medical History

List all **allergies/sensitivities** & reaction (even if minor reaction) For ex: peanuts→trouble breathing *or* dairy→stuffy nose

Drug/Supplement ______________________________

Environment(pollens, etc) ______________________________

Food ______________________________

Other ______________________________

PAST ILLNESSES		IMMUNIZATIONS	
◊ Chicken Pox	◊ Polio	Immunization	Adverse Reaction, if any
◊ Croup	◊ Rheumatic Fever	◊ DPT *(diphtheria, pertussis, tetanus)*	
◊ Ear Infections	◊ Roseola	◊ Diptheria (isolated)	
◊ German Measles	◊ Rubella	◊ Tetanus (isolated)	
◊ Measles	◊ Tonsillitis	◊ MMR *(measles, mumps, rubella)*	
◊ Meningitis	◊ Scarlet Fever	◊ Polio	
◊ Mononucleosis	◊ Strep Throat	◊ Hib (*Haemophilus Type B)*	
◊ Mumps	◊ Other:	◊ Pneumococcus (PCV)	
◊ Pertussis (whooping cough)		◊ Hepatitis B	
◊ Pneumonia		◊ Varicella *(chicken pox)*	
		◊ Other	

List and date all surgeries, hospitalizations, major injuries*:*

Family History

Is your child adopted? ◊ yes ◊ no

Please check any health issues experienced by members of your family?

◊ alcoholism/drug addiction
◊ allergies
◊ arthritis
◊ asthma
◊ autoimmune disease
◊ bleeding disorder
◊ cancer
◊ celiac disease
◊ depression
◊ diabetes
◊ heart disease
◊ high blood pressure
◊ learning challenge
◊ mental illness
◊ obesity
◊ tuberculosis

Are any other significant medical conditions or symptoms present in your family?

Review of Systems

Please circle as follows: (Y)=Yes, a current problem (P)=A past problem*

**For past problems, only circle if significant. Ex: everyone has had a cough due to a cold, so you don't need to circle this unless it was a recurrent/significant problem.*

Current weight: Current length/height:

General ♦

Fatigue	Y	P
Fever/Chills	Y	P
Headaches	Y	P
Loss of/change in appetite	Y	P
Sensitive:		
-to smells/chemicals	Y	P
-to light/noise	Y	P
Colic	Y	P
Bed Wetting	Y	P
Insomnia	Y	P

Skin, Hair, Nails ♦

Cradle cap	Y	P
Dry skin	Y	P
Rashes/itching	Y	P
Acne, boils	Y	P
Slow wound healing	Y	P
Hives	Y	P
Warts	Y	P
Dry, brittle hair/nails	Y	P
Psoriasis	Y	P
Eczema	Y	P

Ears/Eyes ♦

Corrective lenses	Y	P
Impaired vision	Y	P
Dry eyes/tearing	Y	P
Dark circles under eyes	Y	P
Earaches/infections	Y	P
Excessive ear wax	Y	P
Ringing in ear	Y	P
Hearing loss	Y	P

Nose and Sinuses ♦

Sinus problems	Y	P
Runny Nose	Y	P
Post nasal drip	Y	P
Stuffiness	Y	P
Nose bleeds	Y	P

Mouth and Throat ♦

Frequent sore throat	Y	P
Canker sores	Y	P
Cold sores	Y	P
Thrush	Y	P
Teething Pain	Y	P
Dental cavities	Y	P

# of amalgam fillings: ________

Respiratory ♦

Cough	Y	P
Sputum	Y	P
Wheezing	Y	P
Shortness of breath	Y	P
Pain on breathing	Y	P
Asthma	Y	P

Gastrointestinal ♦

Nausea/vomiting	Y	P
Bloating	Y	P
Flatulence(gas)	Y	P
Belching	Y	P
Abdominal pain	Y	P
Reflux	Y	P
Jaundice (yellow skin)	Y	P
Anal itching	Y	P
Diaper Rash	Y	P

Bowel Movements ♦

How often? ____________

Loose stool/diarrhea	Y	P
Constipation	Y	P
Blood in stool	Y	P
Mucus in stool	Y	P
Undigested food in stool	Y	P
Straining or pain w/BM	Y	P
Greasy/fatty stool	Y	P

Urinary ♦

Increased frequency	Y	P
Increased urgency	Y	P
Pain with urination	Y	P
Bladder infection/UTI	Y	P

Cardiovascular ♦

Heart murmur	Y	P
Rheumatic fever	Y	P

Immune/Blood ♦

Anemia	Y	P
Easy bleeding/bruising	Y	P
Chronic/frequent infection	Y	P
Seasonal allergies/hayfever	Y	P
Swollen glands/nodes	Y	P
History of tick bites	Y	P
Epstein Barr virus	Y	P

Musculoskeletal ♦

Joint pain/stiffness	Y	P
Muscle pain	Y	P
Muscle spasm/cramps	Y	P
Trauma/swelling	Y	P

Neurologic ♦

Fainting	Y	P
Seizures/epilepsy	Y	P
Dizziness/vertigo	Y	P
Numbness/tingling	Y	P
Head injury/concussion	Y	P

Endocrine ♦

Cold/heat intolerance	Y	P
Difficult to ↑ weight	Y	P
Difficult to ↓ weight	Y	P
Excessive thirst	Y	P
Excessive hunger	Y	P
Hypoglycemic	Y	P
Diabetes/pre-diabetes	Y	P

Other ♦

Panic attacks	Y	P
Moodiness	Y	P
Eating disorder	Y	P
Attention deficit	Y	P
Hyperactivity	Y	P
Depression	Y	P
Learning challenge	Y	P
Developmental delay	Y	P

Prenatal and Birth History

Mother's age at child's birth ________

Mother's health during pregnancy (check any health issues that were present)

◊ bleeding
◊ illnesses ____________________
◊ strep B
◊ diabetes
◊ nausea
◊ high blood pressure
◊ thyroid problems
◊ physical or emotional trauma
◊ stress and anxiety
◊ cigarette, alcohol, drug consumption
◊ medications: ____________________
◊ other: ____________________

Birth term: full/premature/late Length at birth: ________ Weight at birth: ________

Please check all those that apply to the birth of your child:

◊ C-section ◊ Vaginal birth ◊ Prolonged labor ◊ In hospital ◊ With midwife ◊ Home birth

Did your child have any of the following after birth? (*please check*)

◊ Rashes ◊ Blue baby ◊ Colic ◊ Fever ◊ Jaundice ◊ Birth injuries ◊ Seizures ◊ Difficult feeding

Diet and Lifestyle

SECTION 1

Do/did you breastfeed your child? ◊ Yes, currently ◊ In past for ____ mos/yrs ◊ No **Any difficulties?** ____________________
Do/did you formula feed your child? ◊ Yes, currently ◊ In past for_____mos/yrs ◊ No **Type of formula:** ____________________

If your child is not yet eating solid foods, please skip to section 2.

At what age did you introduce solid foods to your child?____________

Please list the approximate ages at which the following solid foods were introduced into your child's diet:

Soy _____ Cow's Milk _____ Rice_____ Wheat_____ Peanuts/PB_____ Veggies _____ Fruits_____
Fruit Juice _____

Please circle # corresponding to use. **0=never 1=seldom (4x/month or less) 2=moderate (1-4/week) 3=frequent (5-7x/week)**

Cow's Milk	0 1 2 3	Fruit	0 1 2 3	Soy (tofu, milk, etc.)	0 1 2 3
Cheese	0 1 2 3	Vegetables	0 1 2 3	Fish/Seafood	0 1 2 3
Yogurt	0 1 2 3	Beans/legumes	0 1 2 3	Poultry	0 1 2 3
Soda	0 1 2 3	Nuts/seeds	0 1 2 3	Red Meat	0 1 2 3
Fruit Juice	0 1 2 3	White flour products	0 1 2 3	Eggs	0 1 2 3
Snack foods (chips, etc)	0 1 2 3	Whole grains	0 1 2 3		
Sweets (desserts/candy)	0 1 2 3	Potatoes	0 1 2 3	Water	cups/oz per/day
Fast food	0 1 2 3	Brown/white rice	0 1 2 3		

Does your child follow any specific type of diet? If so, please describe (such as vegetarian, vegan, etc):

Please list a typical breakfast, lunch, dinner, and snack for your child:

Breakfast	
Lunch	
Dinner	
Snack	

List any food cravings____

SECTION 2

Average hours of sleep/night? ________ Normal Bedtime ________ Normal waking time ________

Please check those that apply:

◊ Trouble falling asleep initially
◊ Can't fall back to sleep if wake up
◊ Frequent waking in night
◊ Snoring
◊ Grinding teeth
◊ Sensitive sleeper, wakes easily
◊ Wake unrefreshed/irritable
◊ Waking very early in AM

Environment

Have you ever had problems with mold or other environmental toxins at home? ◊Yes ◊No

Have you ever lived in a house with brand new carpet, new furniture, or during or following a remodel? ◊Yes ◊No

Any pets at home? ◊Yes ◊No Type(s): ____________________________________

How often does your child eat organic produce and other products? Never Sometimes Often Always

Social History

What is your child's general disposition?

Parents: ◊Single ◊Married ◊Partnered ◊Separated ◊Divorced ◊Other

Other guardian(s) or close relatives in frequent contact ______________________________

Is your child in ◊ Daycare ◊ Preschool ◊ School Where?______________________________

How many hours each day?____________ How many days of the week?____________

Favorite subjects if in school ______________________________

Any siblings? Please list names and ages:______________________________

Does you child have regular scheduled check-ups with a pediatrician? ◊ Yes ◊ No Last visit: ____________

If there is anything else you would like me to know about your child's health, please use the space below:

Thank you for your time! Once completed, please do one of the following:

- **fax to 888-464-0907**
- **scan document and email to chantewiegand.nd@gmail.com**

By reviewing ahead of time, I will be able to make the most of your first visit. If unable to do so, please bring with you to your first visit, along with any copies of recent lab reports, and bottles of supplements your child is currently taking.