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Patient Information Form (CHILD)

Confidentiality assured

Name: ____ DOB: _____________________

Parent/guardian name/s: ____

Address: ____

Phone: ___________________________ Email: ____

□ Tick if you would prefer not to receive our emails

Name/s and age/s of siblings: ____

Height: ________________________ Weight: ____

Name of GP: ____ Suburb: ________________________

Name of Specialist: ______________________________________ Suburb: __________________________

Specific reason for your appointment and other current health concerns:

1. ____
2. ____
3. ____

Recent pathology/tests/investigations/operations etc:

____

____

____

Current medications (including dosage):

____

____

____

Current supplements (dose and brand):

____

____

Please list any health concerns of family members including siblings, parents and grandparents:

____

____

____

Please list any previous medical history:

____

____

____

Please explain your child's general temperament:

____

____

Has your child taken any antibiotics? If yes, when and how many courses?

____

____

Did you experience any pregnancy complications?

____

____

☐ What was your child's birth weight? ______________________________

☐ Was your child breastfed? Exclusively? ______________ How long? ______________

☐ Was your child formula fed? Which formula? ______________________________

Birth details:

☐ Vaginal delivery

☐ Caesarean section

☐ Forceps delivery

☐ Vacuum extraction

☐ Foetal distress

☐ Low birth weight

☐ Premature delivery

☐ Prolonged labour

Early development:

What age were solids introduced?

____

What age was your child toilet trained?

____

Were milestones achieved on time?

____

General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if your child has never experienced this symptom.

- ☐ Bloating
- ☐ Flatulence
- ☐ Reflux
- ☐ Colic
- ☐ Burping
- ☐ Nausea
- ☐ Daily bowel movements
- ☐ Irregular bowel movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Fussy eating
- ☐ Stomach aches
- ☐ Poor appetite
- ☐ Difficulty gaining weight
- ☐ Recent weight gain

☐ Food intolerances. Please list: ____

____

- ☐ Headaches
- ☐ Sleeping problems
- ☐ Night terrors
- ☐ Bed wetting
- ☐ Clingy
- ☐ Difficult to settle

____

- ☐ Excessive whinging
- ☐ Anxiety
- ☐ Mood swings
- ☐ Poor concentration / focus
- ☐ Socially withdrawn
- ☐ Tantrums

____

- ☐ Recurrent colds and flu
- ☐ Hayfever / sinusitis
- ☐ Asthma
- ☐ Slow wound healing
- ☐ Sneezing, coughing, wheezing
- ☐ Eczema or skin rashes
- ☐ Itchy eyes, ears, nose, throat, skin

____

- ☐ Waxy ears
- ☐ Cradle cap
- ☐ Dry skin

Additional information: ____

____

____

3 DAY DIET DIARY

This diet diary should be completed prior to your appointment with your naturopath and brought with you to your appointment. Please include as much details as possible eg. Type of bread used on sandwiches, whether food is packaged, takeaway or fresh, any dressings or oils used in cooking, any drinks etc….

DAY 1	DAY 2	DAY 3
Breakfast	Breakfast	Breakfast
Morning snack	Morning snack	Morning snack
Lunch	Lunch	Lunch
Afternoon snacks	Afternoon snacks	Afternoon snacks
Dinner	Dinner	Dinner
Other snacks	Other snacks	Other snacks

Water Intake per day –

Coffee/teas per day –

Alcohol per day -