Patient Health Questionnaire - Child

Date: _____

Child's Name: _____ DOB: _____

Address: _____

_____

Home Phone: _____

Parent's Name: _____ Phone: _____

Parent's Name: _____ Phone: _____

Who does the child live with? Mother Father Both Other: _____

Who should we contact in case of an Emergency? (besides parents)

Name: _____ Relationship: _____

Address: _____

Phone numbers: _____

Allergies: _____

_____

_____

_____

Current Medications: _____

_____

_____

_____

Name of Family Physician:_____ Phone:_____

Current weight: _____ Current height: _____

What are your most important health concerns for your child?

Did you notice anything that brought on these concerns? (Exposures, traumas, life changes?)

Is your child currently receiving treatments for these concerns? Have they been effective?

List any screening tests done recently: (Please include dates and results)

List any surgeries, hospitalizations or serious illnesses:

Immunizations:

☐ Diphtheria/Tetanus/Pertussis	☐ Measles/Mumps/Rubella	☐ Influenza
☐ Polio	☐ Varicella (Chicken Pox)	☐ Hepatitis A
☐ Hepatitis B	☐ Smallpox	☐ Other:

Has your child had any adverse reactions to vaccinations? (Please describe)

Has your child had any of the following childhood illness? (Y/N)

☐ Scarlet Fever	☐ Diphtheria	☐ Rheumatic Fever
☐ Mumps	☐ Measles	☐ Rubella (German measles)
☐ Asthma	☐ Chicken Pox	☐ Roseola
☐ Chronic Ear Infections	☐ Strep throat	☐ Other:
☐ Whooping Cough	☐ Mononucleosis	☐ Other:

Prenatal History:

List any problems during pregnancy:

_____

_____

List any drug, alcohol or tobacco use during pregnancy:

_____

_____

List any vitamins, supplements or medications taken during pregnancy:

_____

_____

Description of Birth: (Circle those that apply)

Spontaneous	Epidural	Natural	Late	Pain medication:
Induced	Forceps	C-section	Premature	Other: _____

Birth weight: _____ Birth Length: _____ Head circumference:_____

Neonatal History:

List any difficulties or complications soon after birth:

_____

_____

List any therapies or medications administered:

_____

_____

Growth and Development:

Any concerns regarding physical, emotional or mental development

_____

_____

Nutrition:

Favorite foods: _____ Disliked foods: _____

Typical Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Child & Family History: Circle if current or past concerns for you or your family (include immediate family: aunts, uncles, grandparents)

Arthritis	Self	Current	Father	Mother	Sister	Brother	Other	
Asthma	Self	Current	Father	Mother	Sister	Brother	Other	
Alcoholism	Self	Current	Father	Mother	Sister	Brother	Other	
Cancer	Self	Current	Father	Mother	Sister	Brother	Other	Type:
Cataracts	Self	Current	Father	Mother	Sister	Brother	Other	
Diabetes	Self	Current	Father	Mother	Sister	Brother	Other	Type:
Eczema	Self	Current	Father	Mother	Sister	Brother	Other	
Epilepsy/ Seizures	Self	Current	Father	Mother	Sister	Brother	Other	
Gallbladder Disease	Self	Current	Father	Mother	Sister	Brother	Other	
Glaucoma	Self	Current	Father	Mother	Sister	Brother	Other	
Hay Fever/Hives	Self	Current	Father	Mother	Sister	Brother	Other	
Heart Disease	Self	Current	Father	Mother	Sister	Brother	Other	
Heart Murmur	Self	Current	Father	Mother	Sister	Brother	Other	
High Blood pressure	Self	Current	Father	Mother	Sister	Brother	Other	
Kidney Disease	Self	Current	Father	Mother	Sister	Brother	Other	
Liver Disease	Self	Current	Father	Mother	Sister	Brother	Other	
Mental Illness	Self	Current	Father	Mother	Sister	Brother	Other	Type:
Stroke	Self	Current	Father	Mother	Sister	Brother	Other	
Stroke	Self	Current	Father	Mother	Sister	Brother	Other	
Thyroid disorder	Self	Current	Father	Mother	Sister	Brother	Other	
Tuberculosis	Self	Current	Father	Mother	Sister	Brother	Other	

REVIEW OF SYSTEMS

Please mark the following boxes: C=Current issue, H=Past Issue, Leave blank for never an issue

SKIN			
	Rashes		Lumps
	Eczema, hives		Night Sweats
	Acne, boils		Loss of hair
	Itching		Color change

HEAD	
	Frequent headaches
	Head Injury
	Jaw/TMJ pain
	Migraines/intense headaches

EARS	
	Impaired hearing
	Ringing
	Earache
	Dizziness

EYES			
	Impaired vision		Double vision
	Glasses/contacts		Glaucoma
	Eye pain		Spots in the eyes
	Tearing or dryness		Cataracts

NOSE			
	Frequent colds		Sinus congestion
	Nose bleeds		Loss of smell
	Stuffiness		
	Hay fever		

MOUTH & THROAT			
	Frequent sore throat		Dental cavities
	Sore tongue/lips		Copious saliva
	Gum problems		Difficulty swallowing
	Hoarseness		Cold sores/blisters

NECK	
	Lumps
	Swollen glands
	Goiter
	Pain or stiffness

RESPIRATORY	
	Cough
	Sputum
	Spitting up blood
	Wheezing

RESPIRATORY			
	Asthma		Difficulty breathing
	Bronchitis		Shortness of breath
	Pneumonia		Lying down
	Emphysema		Pain on breathing

CARDIOVASCULAR			
	Chest pain walking		Leg pain walking
	Chest pain lying		Angina
	Ankle swelling		Numbness /
	Palpitations/flutter		tingling in extremities
	Leg vein problems		

GASTROINTESTINAL							
	Heartburn		Abdominal pain		Black stools		Diarrhea
	Change in appetite		Vomiting (w/ blood?)		Alternating symptoms		Constipation
	Nausea		Blood in stool		Belching/passing gas		Hemorrhoids

URINARY			
	Pain on urination		Frequent infections
	Increase frequency		Blood in the urine
	Frequent at night		Kidney stones
	Difficulty holding urine		

MUSCULOSKELETAL	
	Joint pain or stiffness
	Broken bones
	Muscle spasm or cramps
	Weakness

BLOOD	
	Anemia
	Easy bleeding / bruising

PERIPHERAL VASCULAR	
	Deep leg pain
	Cold hands/feet
	Varicose veins
	Thrombophlebitis

NEUROLOGIC	
	Fainting
	Seizures
	Paralysis
	Muscle weakness

MENTAL / EMOTIONAL			
	Numbness or tingling		Mood swings
	Loss of memory		Anxiety/nervousness
	Tremor (shaking, trembling)		Considered /
	Depression		attempted suicide

MENTAL / EMOTIONAL	
	Tension
	Poor concentration
	Memory problems
	Excessive worry

IMMUNE			
	Painful lymph nodes		Difficulty stopping bleeding
	Chronic infections		Chronic Fatigue Syndrome
	Slow wound healing		Chronically swollen glands
	Fluid retention		

CONFIDENTIALITY:

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical record and can request a copy of it by paying the appropriate copying fee.

I understand that my medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for an on behalf of the above-named patient and that I am signing freely and voluntarily.

Do we have permission to leave detailed personal messages on an answering machine or voicemail?
Please Initial: ____ Yes ____ No

Please provide appropriate contact number(s) and sign below:

Phone: _____ (Circle: home cell office other: _____)

And/or: _____ (Circle: home cell office other: _____)

Email address: _____

Would you like to receive a copy of our newsletter or a link to our blog? Yes No

_____ _____
Patient's or Legal Guardian's Signature Date

_____
Printed Patient's Name or Legal Guardian

NATUROPATHIC INFORMED CONSENT TO TREAT

Patient Name: _____

Consent: I herby request and consent to the performance of naturopathic treatments and / or other naturopathic procedures, including various modes of physical exams and diagnostic procedures including venipuncture and lab diagnostics, on me (or on the patient named above, for whom I am legally responsible) by the doctor of naturopathy named above and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

Type of Care: I understand my right to discuss with Dr. Jennifer Strider, N.D. and/or with other clinic personnel the nature and purpose of naturopathic care and procedures. A description of the specific care which is currently contemplated includes homeopathy, botanical medicine, clinical nutrition including vitamins, minerals, amino acids, flower essences, physical medicine and bodywork, lifestyle changes and/or any other therapy that falls within the Naturopathic Doctor's license guidelines, and is agreed upon by patient and doctor.

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, as in the practice of medicine, in the practice of naturopathy, there are some risks to treatment, including, but not limited to: allergic reaction to botanical medicines, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Potential Benefits: Restoration of health and vitality of body and mind, relief of pain and symptoms of disease, education about healthy lifestyle choices for you and your family, and possible prevention of disease or its progression.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's or Legal Guardian's Signature Date

_____

Printed Patient's Name or Legal Guardian