

The Clinic Upstairs  
Jan Dorrell B.Sc. N.D.  
1272 Wellington St. West, 3<sup>rd</sup> Floor  
Tel: (613) 593-8800 Fax: (613) 593-8804

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ (m) (d) (y)  
Parent's Phone (home): \_\_\_\_\_  
(office): \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_  
Who is your child's pediatrician (or family medical doctor)? \_\_\_\_\_

1. What is your chief concern about your child's health?

\_\_\_\_\_  
\_\_\_\_\_

2. What else would you like to see changed in his/her health?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Who diagnosed the condition in #1?

your pediatrician \_\_\_\_\_ a specialist \_\_\_\_\_ other \_\_\_\_\_

Please list specialists consulted for the above condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What was the level of health of both parents prior to conception?

Father: poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

Mother: poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

5. What was the level of health of the mother during pregnancy?

poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What supplements did you take during your pregnancy?

\_\_\_\_\_  
\_\_\_\_\_

7. Did you smoke during pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how many cigarettes per day? \_\_\_\_\_

8. Did you drink alcohol during your pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_  
(If yes, indicated beverage, amount, and frequency)

9. What medications were you on during pregnancy?  
Prescribed \_\_\_\_\_

Over the counter \_\_\_\_\_

10. Would you say your diet during pregnancy was:  
poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

11. How was the birth of this child? Indicate any complications.  
\_\_\_\_\_  
\_\_\_\_\_

12. Was the baby nursed after birth? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, for how long was the baby nursed? \_\_\_\_\_

13. What was the first liquid, apart from water, introduced after the baby  
was weaned (or what was he/she started on if not nursed)?  
\_\_\_\_\_

14. What solid foods were started prior to 6 months of age?  
Food At what month  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. What additional foods were introduced from 6 months of age to 9  
months of age?  
Food At what month  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. What level of health did the baby have in the first six months?  
poor \_\_\_\_\_ fair \_\_\_\_\_ good \_\_\_\_\_ excellent \_\_\_\_\_

17. Did your baby have colic?  
 never \_\_\_\_\_ occasionally \_\_\_\_\_ often \_\_\_\_\_ severe \_\_\_\_\_

18. What vaccinations has your child had?

Vaccination	Age	Adverse Reaction (?)
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19. What was your child's first illness that was given medical attention?

Illness	Age	Treatment
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20. What childhood diseases has your child had? Indicate if it was mild, average, or severe.

	Yes/No	Age	Severity
Roseola			
Rubella (German measles)			
Rubeola (Measles)			
Chicken Pox			
Mumps			
Scarlet Fever			
Pertussis (Whooping cough)			
Strep Throat			
Impetigo			
Mononucleosis			

21. How many times has your child been treated with antibiotics?

22. List all medications your child has taken in the past. If antibiotics, please give the type.

Age	Illness	Medication	Adverse reaction (?)
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23. What medications is your child on now?

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24. What supplements does your child take on a regular basis?

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25. Please give a brief history of the present health concern, giving age of onset, first symptoms, and present symptoms

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26. What are your observations about your child's temperament?

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27. Was your child's physical development:

slower than average \_\_\_\_\_ average \_\_\_\_\_ faster than average \_\_\_\_\_

28. Was your child's mental/emotional development:

slower than average \_\_\_\_\_ average \_\_\_\_\_ faster than average \_\_\_\_\_

29. How is your child's behaviour and performance at school?

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30. Are this child's natural parents:

Married \_\_\_\_\_ Common Law \_\_\_\_\_ Separated \_\_\_\_\_  
Divorced \_\_\_\_\_ Remarried \_\_\_\_\_

31. Does any member of the household smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

32. Are there brothers and/or sisters?

Name	Age	State of health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____