



New Patient - Child

Child's Name	Date	of	Birth
...../...../.....Age.....			
Parent/Guardian's Name	Relationship		
.....			
Address.....			
.....			
Suburb.....	Post	Code	Email
.....			
Phone Numbers: Hm	Wk	Mb	
.....			
Siblings?	Name:	Age:	Name:
.....	Name:	Age:	Name:
.....	Name:	Age:	Name:
.....	Name:	Age:	Name:

Has this child seen a naturopath before? Yes ☐ No ☐

If **yes**, what was the reason for that consultant?

What is your **main** reason for your visit **today**?

Prenatal History

Any difficulties conceiving? No ☐ Yes ☐ — Please explain

Complications during pregnancy No ☐ Yes ☐ — Please list



Ultrasounds during pregnancy No ☐ Yes ☐ — Number

X-rays during pregnancy No ☐ Yes ☐ — Number

Medication during pregnancy No ☐ Yes ☐ — Please list

Cigarettes/alcohol during pregnancy No ☐ Yes ☐ — Please list

Birth History

Age of mother at birth Length of gestation

Location of birth Hospital ☐ Home ☐ Birthing centre ☐

Medications during labour/delivery

Were you induced? No ☐ Yes ☐ — Method of induction

Was your delivery Vaginal ☐ Caesarean section ☐ Emergency ☐

Planned ☐

Length of labour 1st stagehours 2nd stage

Any assistance given during delivery Forceps ☐ Vacuum ☐

Dr./Midwife assisted ☐

Complications during delivery No ☐ Yes ☐ — Please list

Birth weight Birth Length Head circumference

Apgar scores 1 minute 5 minutes

Feeding History

Breast fed No ☐ Yes ☐ — If so how long
.....

Formula fed No ☐ Yes ☐ — If so how long Type
.....



Preferred side of feeding Left ☐ Right ☐ Neither ☐

Introduced to solids atmonths First food

.....

Known (or suspected) food sensitivities

.....

Do you have any concerns about your child's diet No ☐ Yes ☐ — Details

Developmental History

At what age did your child? (*Approximate*)

Hold head up Crawl Sit Stand Walk

.....

Have you noticed any difficulties with the above No ☐ Yes ☐ — Details

Number of hours sleep per night Quality of sleep Good ☐ Fair ☐ Poor ☐

Health History

Has your child experienced any of the following? (please tick):

<input type="checkbox"/> Ear infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Temper tantrums
<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Digestive problems
<input type="checkbox"/> ADHD	<input type="checkbox"/> Constipation	<input type="checkbox"/> Colic	<input type="checkbox"/> Growing/Back pain
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Visual difficulties
<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sore throats	<input type="checkbox"/> Hearing difficulties
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Epilepsy

Other ☐ -

.....



Has your child had any of the following childhood illnesses?

<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Roseola
<input type="checkbox"/>	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Erythema infectiosum

Accident History

Has your child had any significant falls? No ☐ Yes ☐ — Details

Has your child had any accidents? No ☐ Yes ☐ — Details

Is your child involved in any sports?

.....

Has your child ever been hospitalised? No ☐ Yes ☐ — Details

Has your child had surgery? No ☐ Yes ☐ — Details

Are there any genetic disorders in your family? No ☐ Yes ☐ — Details

Has your child any known allergies? No ☐ Yes ☐ — Details

Is there a family history of allergies? No ☐ Yes ☐ — Details



Health History

Prescription medications taken

.....

Vitamin/Mineral/Herbal medications taken

.....

Number of doses of antibiotics taken in the last six months

.....

Total amount of antibiotic use during life time

.....

Vaccination

history.....

Any reactions to vaccinations

.....

Is there anything you believe we should know about your child or their health?

How would you rate your child's health out of 10, with 10 being the best and 0 the worst?

.....

What do you think is holding him/her back from being a 10?

Parent/Guardian's Signature.....

Date.....