



Pediatric Health Profile

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



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 your 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	
		Immunization	Adverse Reaction, if any
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Polio	<input type="checkbox"/> DPT (<i>diphtheria, pertussis, tetanus</i>)	
<input type="checkbox"/> Croup	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diphtheria (isolated)	
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Roseola	<input type="checkbox"/> Tetanus (isolated)	
<input type="checkbox"/> German Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> MMR (<i>measles, mumps, rubella</i>)	
<input type="checkbox"/> Measles	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Polio	
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hib (<i>Haemophilus Type B</i>)	
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Pneumococcus (PCV)	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Other:	<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pertussis (whooping cough)		<input type="checkbox"/> Varicella (<i>chicken pox</i>)	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> 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?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> alcoholism/drug addiction | <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> depression | <input type="checkbox"/> learning challenge |
| <input type="checkbox"/> allergies | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> diabetes | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> cancer | <input type="checkbox"/> heart disease | <input type="checkbox"/> obesity |
| <input type="checkbox"/> asthma | <input type="checkbox"/> celiac disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> tuberculosis |

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

Review of Systems

Please circle as follows: Yes, a current problem 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: _____

<p><u>General</u> ♦</p> <p>Fatigue Y P</p> <p>Fever/Chills Y P</p> <p>Headaches Y P</p> <p>Loss of/change in appetite Y P</p> <p>Sensitive:</p> <p> -to smells/chemicals Y P</p> <p> -to light/noise Y P</p> <p>Colic Y P</p> <p>Bed Wetting Y P</p> <p>Insomnia Y P</p> <p><u>Skin, Hair, Nails</u> ♦</p> <p>Cradle cap Y P</p> <p>Dry skin Y P</p> <p>Rashes/itching Y P</p> <p>Acne, boils Y P</p> <p>Slow wound healing Y P</p> <p>Hives Y P</p> <p>Warts Y P</p> <p>Dry, brittle hair/nails Y P</p> <p>Psoriasis Y P</p> <p>Eczema Y P</p> <p><u>Ears/Eyes</u> ♦</p> <p>Corrective lenses Y P</p> <p>Impaired vision Y P</p> <p>Dry eyes/tearing Y P</p> <p>Dark circles under eyes Y P</p> <p>Earaches/infections Y P</p> <p>Excessive ear wax Y P</p> <p> ringing in ear Y P</p> <p>Hearing loss Y P</p>	<p><u>Nose and Sinuses</u> ♦</p> <p>Sinus problems Y P</p> <p>Runny Nose Y P</p> <p>Post nasal drip Y P</p> <p>Stuffiness Y P</p> <p>Nose bleeds Y P</p> <p><u>Mouth and Throat</u> ♦</p> <p>Frequent sore throat Y P</p> <p>Canker sores Y P</p> <p>Cold sores Y P</p> <p>Thrush Y P</p> <p>Teething Pain Y P</p> <p>Dental cavities Y P</p> <p># of amalgam fillings: _____</p> <p><u>Respiratory</u> ♦</p> <p>Cough Y P</p> <p>Sputum Y P</p> <p>Wheezing Y P</p> <p>Shortness of breath Y P</p> <p>Pain on breathing Y P</p> <p>Asthma Y P</p> <p><u>Gastrointestinal</u> ♦</p> <p>Nausea/vomiting Y P</p> <p>Bloating Y P</p> <p>Flatulence(gas) Y P</p> <p>Belching Y P</p> <p>Abdominal pain Y P</p> <p>Reflux Y P</p> <p>Jaundice (yellow skin) Y P</p> <p>Anal itching Y P</p> <p>Diaper Rash Y P</p>	<p><u>Bowel Movements</u> ♦</p> <p>How often? _____</p> <p>Loose stool/diarrhea Y P</p> <p>Constipation Y P</p> <p>Blood in stool Y P</p> <p>Mucus in stool Y P</p> <p>Undigested food in stool Y P</p> <p>Straining or pain w/BM Y P</p> <p>Greasy/fatty stool Y P</p> <p><u>Urinary</u> ♦</p> <p>Increased frequency Y P</p> <p>Increased urgency Y P</p> <p>Pain with urination Y P</p> <p>Bladder infection/UTI Y P</p> <p><u>Cardiovascular</u> ♦</p> <p>Heart murmur Y P</p> <p>Rheumatic fever Y P</p> <p><u>Immune/Blood</u> ♦</p> <p>Anemia Y P</p> <p>Easy bleeding/bruising Y P</p> <p>Chronic/frequent infection Y P</p> <p>Seasonal allergies/hayfever Y P</p> <p>Swollen glands/nodes Y P</p> <p>History of tick bites Y P</p> <p>Epstein Barr virus Y P</p>	<p><u>Musculoskeletal</u> ♦</p> <p>Joint pain/stiffness Y P</p> <p>Muscle pain Y P</p> <p>Muscle spasm/cramps Y P</p> <p>Trauma/swelling Y P</p> <p><u>Neurologic</u> ♦</p> <p>Fainting Y P</p> <p>Seizures/epilepsy Y P</p> <p>Dizziness/vertigo Y P</p> <p>Numbness/tingling Y P</p> <p>Head injury/concussion Y P</p> <p><u>Endocrine</u> ♦</p> <p>Cold/heat intolerance Y P</p> <p>Difficult to ↑ weight Y P</p> <p>Difficult to ↓ weight Y P</p> <p>Excessive thirst Y P</p> <p>Excessive hunger Y P</p> <p>Hypoglycemic Y P</p> <p>Diabetes/pre-diabetes Y P</p> <p><u>Other</u> ♦</p> <p>Panic attacks Y P</p> <p>Moodiness Y P</p> <p>Eating disorder Y P</p> <p>Attention deficit Y P</p> <p>Hyperactivity Y P</p> <p>Depression Y P</p> <p>Learning challenge Y P</p> <p>Developmental delay Y P</p>
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Prenatal and Birth History

Mother's age at child's birth _____

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

- | | | |
|-------------------|--------------------------------|--|
| ♦ bleeding | ♦ nausea | ♦ stress and anxiety |
| ♦ illnesses _____ | ♦ high blood pressure | ♦ cigarette, alcohol, drug consumption |
| ♦ strep B | ♦ thyroid problems | ♦ medications: _____ |
| ♦ diabetes | ♦ physical or emotional trauma | ♦ 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 _____

<i>Please check those that apply:</i>	<input type="checkbox"/> Snoring	<input type="checkbox"/> Wake unrefreshed/irritable
<input type="checkbox"/> Trouble falling asleep initially	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Waking very early in AM
<input type="checkbox"/> Can't fall back to sleep if wake up	<input type="checkbox"/> Sensitive sleeper, wakes easily	
<input type="checkbox"/> Frequent waking in night		

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 your 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:

- mail to PO Box 579, Driggs, ID 83422 (if appt is at least 2 days away if you live in the area)
- fax to 208.354.9578 (Driggs) or 208.522.7711 (Cottage in IF if day of appt)
- scan document and email to chantewiegand.nd@gmail.com
- drop off at my office at 189 N Main, Suite 114 in Driggs (access and parking via Ashley Avenue)

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.