true nature
HEALTH CLINIC

CONFIDENTIAL CHILDREN'S HEALTH QUESTIONNAIRE

To be completed by Parent.

Name _____ Date _____
Name of Parent/Guardian's: _____
Emergency contact: _____
Address _____ City _____
Province _____ Postal code _____
Home Phone #_____ Cell # _____
Office #_____ ext. _____
Date of Birth: _____ Age ___ Alberta Health Care # _____
Sex: Male ☐ Female ☐ Height_____ Weight _____

Name of Family Medical Doctor _____

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

_____
_____
_____
_____
_____

Child's past medical history (Surgeries, Hospitalizations)

_____
_____
_____
_____
_____

Immunizations (check the ones your child has had)

Measles, Mumps, Rubella ☐
Diptheria, Pertussis, tetanus ☐
Polio ☐
Influenza ☐
Smallpox☐
Hepatitis ☐

240-11808 St. Albert Trail NW
Edmonton, AB T5L 4G4
p: 780-944-2780
truenaturehealth.ca
reception@truenaturehealth.ca
truenaturehealth.ca

Has your child had any reactions to any immunizations? Yes ☐ No ☐

Childhood Illnesses (please check)

Chickenpox ☐
Rheumatic fever ☐
Mumps ☐
Frequent colds ☐
Tonsillitis ☐
Measles ☐
Other ☐

Scarlet Fever ☐
Pneumonia ☐
Rubella ☐
Ear Infection ☐
Allergies ☐

_____
_____
_____

Symptoms (use "check" for current problem) (use "P" for past problems)

Eczema ☐
Burning of Urine ☐
Nervous ☐
Nosebleeds ☐
Frequent Urination ☐
Cough ☐
Bruises easily ☐
Ear Infection ☐
Frequent Colds ☐
Sleep problems ☐

Bed wetting ☐
Diarrhea ☐
Blood in Urine ☐
Tendency to bleed ☐
Night sweats ☐
Constipation ☐
Sore throat ☐
Hair loss ☐
Fatigue ☐

Change in appetite ☐
Unusual fears ☐
Stomach issues ☐
Hearing loss ☐
Body/breath odor ☐
Unusual Fears ☐
Tendency to bleed ☐
Change in appetite ☐

Family History [please put M (Mother), F (Father), S (sibling), or G (Grandparent)]

Allergies ____
Birth defects ____
Arthritis ____
Cancer _____
Heart disease ____
Other _____

Diabetes ____
Hypertension ____
Mental Illness ____
Tuberculosis ____

240-11808 St. Albert Trail NW
Edmonton, AB T5L 4G4
p: 780-944-2780
truenaturehealth.ca
reception@truenaturehealth.ca
truenaturehealth.ca

true nature
HEALTH CLINIC

Prenatal History

Mother's age at childbirth: ____
Mother's health during pregnancy (check appropriate boxes)

Bleeding ☐
Hypertension ☐
Cigarette/alcohol/ drug use ☐
Illness ☐
Medications ☐
Diabetes ☐
Thyroid problems ☐
Physical or emotional trauma ☐
Nausea ☐

Other:

_____

_____

Birth History

Term (please check)
Full ☐ Premature ☐ Late ☐

Weight at birth: _____ Length of labour: _____

Complications:_____

_____

_____

Was delivery by: C-Section ☐ or Vaginal birth ☐

Did your infant experience any of the following at birth or soon after?
Jaundice ☐ Seizures ☐ Birth injuries ☐
Colic ☐ Birth defects☐ Rashes ☐
Other:

_____

_____

General Information:

Child's sleep pattern (first year):

_____

_____

_____

240-11808 St. Albert Trail NW
Edmonton, AB T5L 4G4
p: 780-944-2780
truenaturehealth.ca
reception@truenaturehealth.ca
truenaturehealth.ca

Food Intolerance/allergies:

_____

_____

Feeding:
Breast Fed ☐ How long? _____
Formula ☐
Milk/Soy ☐

Age child began solid foods: _____
What were some of the first foods introduced?

_____

_____

_____

_____

Has there been any slow development in the areas of sitting/crawling/walking/speaking?
If yes, describe

_____

_____

_____

_____

Diet in a typical day:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids: _____

Medications/Supplements:

_____

_____

_____

240-11808 St. Albert Trail NW
Edmonton, AB T5L 4G4
p: 780-944-2780
truenaturehealth.ca
reception@truenaturehealth.ca
truenaturehealth.ca

true nature HEALTH CLINIC

Food Tracker

Day	Breakfast	Lunch	Dinner	Snacks
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Please write down everything that you eat or drink

240-11808 St. Albert Trail NW
Edmonton, AB T5L 4G4
p: 780-944-2780
truenaturehealth.ca
reception@truenaturehealth.ca
truenaturehealth.ca