Dr. Anita Komonski, B.Sc., ND

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New Patient Health History Questionnaire – Pediatric

Patient Name: _____ Date:_____
PLEASE PRINT (Last) (First) (Middle)

Successful comprehensive health care is only possible when the physician has a complete understanding of the patient's physical, mental and emotional condition and history. Please answer each question completely, marking anything you have a question about. Your time, thoughtfulness and honesty is appreciated and will greatly aid me in evaluating your child's health needs. All answers are completely confidential.

MSP #_____ Date of Birth_____ Age_____ Gender_____

Parent/Guardian Name:_____ Relation to child:_____
Address _____
Phone (home)_____ (work)_____ Email _____

Parent/Guardian Name:_____ Relation to child:_____
Address _____
Phone (home)_____ (work)_____ Email _____

Who does the child live with?_____

How did you hear about Dr. Komonski?_____

Medical doctor, pediatrician and other health care providers:
1. _____ 2. . _____ 3. . _____
_____ _____ _____
_____ _____ _____
(____)_____ (____)_____ (____)_____

In order of importance, what are your child's health concerns? List as many as you can, including when they started.
1. _____ onset_____ 2. _____ onset_____
3. _____ onset_____ 4. _____ onset_____
5. _____ onset_____ 6. _____ onset_____

What kind of treatment has your child received?_____

Can you identify any factors (traumas, drug reactions, surgery, events) that may have caused or aggravated your child's health concerns?

Does your child have any known contagious diseases at this time? N Y _____
Does your child have any known life-threatening allergies? N Y_____

MEDICAL HISTORY
How would you describe your child's general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical exam_____ Height_____ Weight_____

Please list any major illnesses, injuries, hospitalizations or surgeries, along with approximate dates
_____ date_____ _____ date_____
_____ date_____ _____ date_____

Does your child have any allergies/sensitivities (drugs/foods/animals/plants/pollen)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics).
_____
_____
_____
_____

Please list all past prescription medications.
_____
_____

Approximately how many times has your child been treated with antibiotics?_____

Please indicate what immunizations your child has received.

□ DPT (Diptheria, pertussis, tetanus)	□ Haemophilus Influenza B	□ Flu
□ MMR (Measles, mumps, rubella)	□ Hepatitis B	□ Hepatitis A
□ Chickenpox	□Tetanus booster	□Other_____

Any adverse reactions? _____

Which of the following has your child had?

□ Rubella (German measles)	□ Roseola	□ Measles	□ Scarlet Fever
□ Chicken pox	□ Whooping cough	□ Mumps	□ Strep throat
□ Impetigo	□ Mononucleosis	□ Ear infections	□ Frequent colds

Has your child been to see the dentist? □ Yes □ No
Has your child had any dental work? □ No □ Yes_____

What screening tests has your child had (blood, hearing, vision, etc.)_____
_____

Has your child had any of the following conditions? Please circle "Y" if they have the condition presently, and "P" if they had it in the past.

Jaundice	Y	P	Colic	Y	P
Eczema/rash	Y	P	Stomach aches	Y	P
Breathing problems	Y	P	Diarrhea	Y	P
Bronchitis	Y	P	Constipation	Y	P
Pneumonia	Y	P	Teeth problems	Y	P
Asthma	Y	P	Vision problems	Y	P
Tonsilitis	Y	P	Hearing problems	Y	P
Sinusitis	Y	P	Nose bleeds	Y	P
Heart murmur	Y	P	Cold sores	Y	P
Head lice	Y	P	Pink eye	Y	P
Cancer	Y	P	Thrush	Y	P
Chronic bruising	Y	P	Urinary tract infection	Y	P

Headaches	Y	P	Nervous child	Y	P
Bedwetting	Y	P	Convulsions	Y	P
Difficulty concentrating	Y	P	Tantrums	Y	P
Hyperactivity	Y	P	Lack of energy	Y	P
Difficult to please	Y	P	Cries a lot	Y	P
Difficulty sleeping	Y	P	Bowel movements per day: _____ Colour:_____		

PRENATAL HISTORY

What was the state of health of the parents at conception?
Mother_____ Father_____

How was the mother's health during pregnancy? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Did the mother experience any of the following during the pregnancy?
☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid problems ☐ Physical trauma ☐ Emotional trauma
☐ Other_____

What was the mother's age at child's birth? _____ Number of previous pregnancies carried to term?_____

Did the mother use any of the following during pregnancy?
☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Recreational drugs (please specify)_____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements: _____

Were there any interventions used during pregnancy? (eg. ultrasound, amniocentesis, suction, antibiotics)
_____

BIRTH HISTORY

Delivery: ☐ Vaginal ☐ Caesarian Where? ☐ Home ☐ Hospital
Difficult? ☐ Yes ☐ No Hours of labour:_____

Where there any complications or interventions used during the delivery? (epidural, forceps, induction, emergency c-section) _____

Term length: ☐ Full ☐ Premature:_____wks ☐ Late:_____wks Weight at birth: _____

Did the child experience any of the following at or shortly after birth?
☐ Jaundice ☐ Rashes ☐ Seizures
☐ Birth defects _____ ☐ Infections _____
☐ Respiratory distress ☐ Birth injuries_____

DIET HISTORY

How was your child fed as an infant?
☐ Breast-fed. How long? _____ ☐ Formula. Milk/soy/other:_____ ☐ Combination

What types of foods were introduced and in what order? (Please list approximate month also.)
_____
_____
_____
_____

Did your child have any reaction to the foods being introduced? _____
_____

Please describe a typical day's diet for your child.
Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Does the child crave any foods? Which ones? _____

FAMILY HISTORY
Please indicate if a close relative has had any of the following conditions, specifying whom [mother (M), father (F), sibling (S), maternal grandparent (MG), paternal grandparent (PG)].

☐ Diabetes	☐ Heart disease	☐ Stroke	☐ Cancer (include type)
☐ Seizures	☐ Asthma	☐ Allergies	☐ Bleeding disorder
☐ Arthritis	☐ Kidney disease	☐ Mental illness	☐ Birth defects
☐ Other:_____			

Do either of the parents have a chronic illness? _____

LIFESTYLE & ENVIRONMENT
Does anyone in the household smoke? ☐ No ☐ Yes Are there pets in the house? ☐ No ☐ Yes _____

How is the child's home heated? _____

How is the child's sleep? (number of hours, sleep through the night, trouble falling, nightmares)

What is the emotional climate in the child's home? _____
_____

Is your child in: ☐ Day care ☐ Home school ☐ School Grade level_____

Does your child watch television? ☐ No ☐ Yes How many hours per day? _____
Does your child play video games? ☐ No ☐ Yes How many hours per day? _____
Does your child read? ☐ No ☐ Yes How many hours per day? _____

What are your child's favorite activities? _____

Does the child exercise regularly? ☐ Yes ☐ No How much, how often?
_____
_____

How would you describe the child's personality?

Thank you for your time and effort. I look forward to providing you with the best possible care.

Declaration and Informed Consent to Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic physician I will conduct a thorough case history, a physical exam, and may utilize specific blood and/or urinary laboratory reports as part of the treatment work-up. I use supportive therapies such as nutrition counseling, botanical medicine, acupuncture/traditional Chinese medicine, supplementation, hydrotherapy, bodywork, homeopathy and lifestyle counseling to assist the body's innate healing capacity and to improve overall health and wellbeing.

Statement of Acknowledgement

Printed name_____

As a patient of Dr. Anita Komonski, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information provided is complete, accurate and inclusive of all health concerns including the risk of pregnancy and all medications, including over the counter drugs and supplements. **Slight** health risks of some naturopathic treatments include, but not limited to: temporary aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and spasms, and disc injuries from spinal manipulations.

I also recognize the following:

- Information revealed during the course of a visit is **strictly confidential**. Exceptions to this confidentiality include disclosure regarding intention to seriously harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor.
- A record will be kept of my visits. This record and the information provided **will not be disclosed** to others without my consent, or unless the law compels or authorizes Dr. Komonski to do so. I understand that I may look at my medical records at any time and can request a copy of them.
- I will be given the opportunity to discuss and ask questions regarding any treatment plan. I have the ability to **accept or reject this care** of my own free will and choice.
- Any treatment or advice provided to me as a patient of Dr. Komonski is **not mutually exclusive** from any treatment I may now be receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care from a medical doctor or other licensed healthcare provider. I will inform Dr. Komonski of other treatments that I may be receiving concurrently, or plan to receive while following her treatment plan. I understand that results are not guaranteed.
- I am responsible for **full payment** at the time of each visit for services, cost of supplements/botanicals, lab tests or other fees. I am aware that these fees are not covered by MSP; in the case of premium assistance, I will pay all fees up front and request a reimbursement card from Dr. Komonski.
- I am aware that a **minimum of 24 hours notice** must be given for all rescheduled or cancelled appointments. The full fee will be charged for missed sessions without such notification.
- I understand that Dr. Komonski reserves the right to determine which cases fall outside her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment from Dr. Anita Komonski. I understand this consent is voluntary and may be revoked at any time.

Signature of parent or legal guardian:_____ Date: _____