In Natures Hands

Patient Information Form (CHILD)

Confidentiality assured

Name: _____ DOB: _____

Parent/guardian name/s: _____

Address: _____

Phone: _____ Email: _____

□ Tick if you would prefer not to receive our emails

Name/s and age/s of siblings: _____

Height: _____ Weight: _____

Name of GP: _____ Suburb: _____

Name of Specialist: _____ Suburb: _____

Specific reason for your appointment and other current health concerns:

1. _____
2. _____
3. _____

Recent pathology/tests/investigations/operations etc:

_____

_____

_____

Current medications (including dosage):

_____

_____

_____

Current supplements (dose and brand):

Please list any health concerns of family members including siblings, parents and grandparents:

Please list any previous medical history:

Please explain your child's general temperament:

Has your child taken any antibiotics? If yes, when and how many courses?

Did you experience any pregnancy complications?

- ☐ What was your child's birth weight? _____
- ☐ Was your child breastfed? Exclusively? _____How long? _____
- ☐ Was your child formula fed? Which formula? _____

Birth details:

- ☐ Vaginal delivery
- ☐ Caesarean section
- ☐ Forceps delivery
- ☐ Vacuum extraction
- ☐ Foetal distress
- ☐ Low birth weight
- ☐ Premature delivery
- ☐ Prolonged labour

Early development:

What age were solids introduced?

_____

What age was your child toilet trained?

_____

Were milestones achieved on time?

_____

General Health Questionnaire:

Below are a series of health symptoms. Please check boxes with a tick for present symptoms and a cross for past symptoms. Please leave the box blank if your child has never experienced this symptom.

- ☐ Bloating
- ☐ Nausea
- ☐ Fussy eating
- ☐ Flatulence
- ☐ Daily bowel movements
- ☐ Stomach aches
- ☐ Reflux
- ☐ Irregular bowel movements
- ☐ Poor appetite
- ☐ Colic
- ☐ Constipation
- ☐ Difficulty gaining weight
- ☐ Burping
- ☐ Diarrhoea
- ☐ Recent weight gain
- ☐ Food intolerances. Please list: _____

_____

- ☐ Headaches
- ☐ Night terrors
- ☐ Clingy
- ☐ Sleeping problems
- ☐ Bed wetting
- ☐ Difficult to settle

_____

- ☐ Excessive whinging
- ☐ Mood swings
- ☐ Socially withdrawn
- ☐ Anxiety
- ☐ Poor concentration / focus
- ☐ Tantrums

_____

- ☐ Recurrent colds and flu
- ☐ Slow wound healing
- ☐ Itchy eyes, ears, nose, throat, skin
- ☐ Hayfever / sinusitis
- ☐ Sneezing, coughing, wheezing
- ☐ Asthma
- ☐ Eczema or skin rashes

_____

- ☐ Waxy ears
- ☐ Cradle cap
- ☐ Dry skin

Additional information: _____

_____

_____