HOPEWELL
NATUROPATHIC
FAMILY MEDICINE
YOUR PARTNER IN GOOD HEALTH

**Kasia Hopewell, ND**
**1601 El Camino Real, Suite 101**
**Belmont, CA 94002**
**TEL: 650-591-9355**

# Child's Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Name:_____ ☐ M ☐ F Date:_____ DOB:_____ Age:_____

Parents'/Guardians'Names:_____

Please list your child's primary care physician (PCP) and any other healthcare providers you consult with.

| Healthcare Provider: | Type of Practice: | Phone Number: |
|---|---|---|
| *Dr. Anna Smith (PCP)* | *DO* | *425.555.1212* |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Date of last physical exam: _____

Date of last blood draw: _____

Please list your child's present health concerns in order of their importance.

| Concern: | Date of Onset: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

What are your goals for this visit?

_____

_____

Traumas, car accidents, injuries:

_____

_____

Please list prior hospitalizations:

| Reason: | Date/Where: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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Please list your child's previous medical diagnoses.

1. Diagnosis_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

_____ _____
_____ _____ _____
_____ _____ _____

What do you hope for as we work together to treat this problem naturopathically?

_____

2. Diagnosis_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

_____ _____
_____ _____ _____
_____ _____ _____

What do you hope for as we work together to treat this problem naturopathically?

_____

3. Diagnosis_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

_____ _____ _____
_____ _____ _____
_____ _____ _____

What aggravates your condition? What helps your condition? In your mind, what caused this problem?

_____ _____
_____ _____ _____
_____ _____ _____

What do you hope for as we work together to treat this problem naturopathically?

_____

4. Diagnosis_____ Date of Onset:_____ Doctor Involved:_____

Current symptoms: Current treatments: Treatments received in the past:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

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What aggravates your condition? _____

What helps your condition? _____

In your mind, what caused this problem? _____

What do you hope for as we work together to treat this problem naturopathically?

_____

Please list any prescription medications your child is currently taking.

| Medication: *Eg. Lipitor* | Reason: *High cholesterol* | Year Started: *2000* | Dosage: *10mg once daily* |
|---|---|---|---|
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Please list any over the counter medication your child is currently taking.

| Medication: *Eg. Advil* | Reason: *Pain relief* | Frequency: *3 times/week* | Dosage: *250mg twice daily* |
|---|---|---|---|
| | | | |
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| | | | |

Please list any nutritional supplements, herbs, or homeopathics your child is currently taking.

| Supplement/Manufacturer/Form: *Eg. Quercetin/Natural Factors/capsules* | Reason: *Allergies* | Date Started: *May 10, 2004* | Dosage: *235mg 3x/daily* |
|---|---|---|---|
| | | | |
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Please list any known allergies your child has.

| Drug Allergy: | Food Allergy: | Environmental Allergy: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## Family Health History

Is your child adopted? ☐ Yes ☐ No

Please check if your child has any of the following family history:

| | | | | |
|---|---|---|---|---|
| ☐ Alcoholism | ☐ Autoimmune dz | ☐ Epilepsy | ☐ Kidney disease | ☐ Thyroid disorder |
| ☐ Allergies | ☐ Cancer | ☐ Heart attack | ☐ Obesity | ☐ Other – |
| ☐ Anxiety | ☐ Depression | ☐ Heart disease | ☐ Osteoporosis | Please list: |
| ☐ Arthritis | ☐ Diabetes | ☐ Hypertension | ☐ Stroke | |

| | Current Age | Age of Death | Significant health problem or cause of death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers/Sisters (list) | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |

*Please leave this space blank for doctor use*

## Medical History

Any complications during the child's mother's pregnancy? ☐ Yes ☐ No

If so, please describe: _____

Patient Name _____ DOB _____ Date _____

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Please check the box that describes how your child was born:
☐ Vaginal ☐ C-section ☐ Forceps ☐ Vacuum ☐ Trauma?

Any newborn problems?
☐ Jaundice ☐ Extended hospitalization ☐ Other, please describe:

As a baby, this child was fed:
☐ Breastmilk ☐ Formula ☐ Mixed

Do you know at what age your child was first given solid foods?_____

If formula fed, what kind of formula? _____

If breastfed, how long? _____

Please indicate if your child has had any of the following childhood illnesses.
☐ Acne ☐ Chicken pox ☐ Mono pox ☐ Pertussis ☐ Rubella ☐ Scarlet Fever
☐ ADD ☐ Measles ☐ Mumps ☐ Polio ☐ Rheumatic ☐ Other:

How often does your child get sick? _____

What kind of illnesses do they usually experience? *Eg. Ear infections, sore throat, cough, allergies, asthma...*

_____

How often has your child taken antibiotics?

_____

Please describe your child's vaccination history.
☐ Fully vaccinated ☐ Selectively vaccinated ☐ Not vaccinated
Check the vaccinations that your child has had:
☐ Chicken pox ☐ Hepatitis B ☐ MMR ☐ Polio ☐ Other: _____
☐ DPT ☐ HIB ☐ Pneumonia ☐ PPD _____

Last tetanus booster: _____

Does your child get the flu vaccine? _____

Has your child ever had an adverse reaction to a vaccine? ☐ Yes ☐ No

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## Other Lifestyle Factors

Please describe your child's physical activity level:

- ☐ Sedentary *Eg. No exercise*
- ☐ Mild exercise *Eg. Climb stairs, walk 3 blocks, golf*
- ☐ Occasional exercise *Eg. Work or recreation for 30 minutes duration less than 4 times weekly*
- ☐ Regular vigorous exercise *Eg. Work or recreation for 30 minutes more than 4 times weekly*

After moderate or vigorous exercise, how do you feel? ☐ Great ☐ Drained

Please list your child's current body weight: _____
Does your child diet to lose weight? ☐ Yes ☐ No
Does your child take medications, herbs, or supplements to lose weight? ☐ Yes ☐ No
Does your child have, or have you ever had, an eating disorder? ☐ No ☐ Binging ☐ Purging ☐ Avoidance of food

BMI *Please leave blank for doctor use*

Please list who your child currently lives with. *Eg. parents, siblings, roommates, pets*

| Name | Age | Relationship | Name | Age | Relationship |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Is the home a sanctuary for your child? ☐ Yes ☐ No
Does your child's home have lead paint? ☐ Yes ☐ No
Is your child's home moldy? ☐ Yes ☐ No
Is your child's home safe? ☐ Yes ☐ No
Is there a gun in your home? ☐ Yes ☐ No
Is your child having any difficulties in school?
_____
_____
Does anyone in your home smoke or use drugs regularly?_____

Please check off any potential toxic exposures.

- ☐ Anesthesia
- ☐ Asbestos
- ☐ Cleaning chemicals
- ☐ Electric power lines
- ☐ Frequent air travel
- ☐ Glassblowing
- ☐ Lead paint
- ☐ Mercury fillings
- ☐ Model building
- ☐ Nuclear power plant
- ☐ Painting
- ☐ Pesticides
- ☐ Pottery
- ☐ Second-hand smoke
- ☐ Other heavy metals
- ☐ Other mercury exposure
- ☐ Other solvents

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## Dietary Assessment and Habits

How many times a week does your child eat red meat (beef, lamb, pork, etc.)?

How many times a week does your child eat fish?

How many times a week does your child eat poultry (chicken, turkey, duck, etc)?

How many times a week does your child eat beans?

How many times a week does your child eat soy (tofu, soy milk, tempeh, etc)?

How many times a week does your child eat dairy products (milk, ice cream, yogurt, etc) and what quantity?

How many fruits does your child eat each day and what quantity?

How many vegetables does your child eat each day and what quantity?

How many sweets or desserts does your child eat each day? What types?

How many times does your child eat out each week?

How many times does your child eat 'fast food' each week?

How many glasses of water does your child drink each day (1 glass=8 oz.)?

How many glasses of other drinks does your child have each day? What types?

Please list any foods that your child craves.

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## Recall of Dietary Intake

Please list all foods and drinks your child has consumed in the previous 48 hours. Include meals, snacks, beverages and condiments.

Breakfast

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Lunch

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Dinner

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Patient Name _____ DOB _____ Date _____

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Snacks

| | Food Item | Preparation *Eg. Baked, fried* | Amount |
|---|---|---|---|
| Day 1 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Day 2 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Alcohol, Tobacco, and Drug Intake

Does your child drink alcohol, use tobacco or other recreational or street drugs? □ Yes□ No

Caffeine

Does your child drink soda, coffee, caffeinated tea? □Yes □ No Amount: _____

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# Elimination

## Gut

How often does your child have a bowel movement? _____

Does their stool have any of the following qualities?

| | | | | |
|---|---|---|---|---|
| ☐ Undigested food | ☐ Formed | ☐ Dry | ☐ Tan | ☐ Yellow |
| ☐ Bright red blood | ☐ Loose | ☐ Greasy | ☐ Black | ☐ Other: |
| ☐ Mucus | ☐ Hard | ☐ Brown | ☐ Green | |

Do they strain to pass stool? ☐ Yes ☐ No

Do they experience gas, bloating, belching? ☐ Yes ☐ No

Do they have hemorrhoids? ☐ Yes ☐ No

Do they ever unintentionally pass stool? ☐ Yes ☐ No

Please check any box that applies to your child.

| | | | |
|---|---|---|---|
| ☐ Abdominal pain | ☐ Nausea/vomiting | ☐ Diarrhea | ☐ Recent change in bowel habits |
| ☐ Heartburn/Indigestion | ☐ Constipation | ☐ None | |

## Kidneys

How often do they urinate? _____

Please check any box that applies to your child.

| | | |
|---|---|---|
| ☐ Pain with urination | ☐ Must get up at night to urinate | ☐ Kidney stones |
| ☐ Urinate too frequently | ☐ Leaking urine when coughing or laughing | ☐ Recurrent urinary tract infection |
| ☐ Urgency to urinate | | ☐ Other |
| ☐ Urinary flow obstruction | ☐ Leaking urine at other times | ☐ None |
| ☐ Dribbling at end of urination | | |

## Skin

Do they sweat easily? ☐ Yes ☐ No

Do they use antiperspirant? ☐ Yes ☐ No

Do they apply lotions or oils to you skin? ☐ Yes ☐ No

Do they scrub or dry brush their skin? ☐ Yes ☐ No

What type? _____

Please note if your child has any of the following:

| | | | |
|---|---|---|---|
| ☐ Acne | ☐ Dry skin | ☐ Skin cancer | ☐ Pigment changes |
| ☐ Eczema | ☐ Contact dermatitis | ☐ Hair loss or unusual growth | ☐ None |
| ☐ Rash | ☐ Moles | | |
| ☐ Chronic itching | ☐ Hives | ☐ Yellowing of the skin | |

## Lungs

Please note if your child has any of the following.

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Difficulty breathing | ☐ Recurrent lung infections | ☐ Painful breathing |
| ☐ Chronic cough | ☐ Can't sleep flat | | ☐ None |

## Liver

Please note if your child has any of the following.

| | | | |
|---|---|---|---|
| ☐ Yellowing of the skin | ☐ Nausea/vomiting | ☐ PMS | ☐ None |
| ☐ Chronic itching | ☐ Abdominal pain | ☐ Menstrual irregularity | |

Are they unable to tolerate any of the following.

| | | | |
|---|---|---|---|
| ☐ Cigarette smoke | ☐ Perfume | ☐ Alcohol | ☐ Caffeine |

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# Review of Systems

Please check if your has, or has had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.

## Constitutional

☐ Weight ☐ Appetite ☐ Sense of wellbeing
☐ Energy level ☐ Strength ☐ Ability to sleep
☐ Sleep ☐ Night sweats ☐ None

## Eyes, ears, nose, mouth, throat

☐ Vision loss ☐ Hearing loss ☐ Headaches
☐ Double vision ☐ Ringing in the ears ☐ Missing teeth
☐ Excessive tearing ☐ Vertigo/dizziness ☐ Gingivitis
☐ Dry eyes ☐ Nose bleeds ☐ Bad breath
☐ Blind spots ☐ Chronic stuffy nose ☐ Neck stiffness or swelling
☐ Eye pain ☐ Post nasal drip ☐ None
☐ Eye discharge ☐ Recurrent sinus infection

## Heart and blood vessels

☐ Chest wall pain ☐ Heart murmur ☐ Fainting
☐ Palpitations ☐ Varicose veins ☐ Swelling
☐ Short of breath w/ mild exercise ☐ Clotting disorder ☐ Leg pain when walking
☐ Short of breath lying flat ☐ Vessel inflammation ☐ Anemia ☐ None

## Lungs

☐ Painful breathing ☐ Cough ☐ Coughing blood
☐ Shortness of breath ☐ Chronic bronchitis ☐ None
☐ Wheezing ☐ Coughing sputum

## Musculoskeletal

☐ Back pain ☐ Muscle cramps ☐ Hot/red muscles or joints
☐ Scoliosis ☐ Muscle pain ☐ Limited range of motion
☐ Bone loss/fractures ☐ Joint pain ☐ None
☐ Muscle weakness ☐ Morning stiffness

## Neurologic and psychological

☐ Seizures/convulsions ☐ Incoordination ☐ Bipolar disorder
☐ Paralysis ☐ Speech difficulties ☐ Suicidal history
☐ Numbness/tingling ☐ Anxiety ☐ None
☐ Tremor ☐ Depression

## Endocrine

☐ Breast enlargement – males ☐ Excessive urination ☐ Waking at night
☐ Thyroid problems ☐ Excessive thirst ☐ Fainting
☐ Heat or cold intolerance ☐ Spacey feeling after food ☐ Swelling ☐ None