Dr. Vivian Lord, N.D.
NATUROPATHIC DOCTOR
Natural Approaches to Women's Health

Child Health Questionnaire
(0 – 12 years)

Please scan and email completed form to ***info@drvivianlord.com****, send by mail or bring it with you to your first appointment.*

Name: *(Last)* _____ *(First)* _____ *(Middle Initial)* ____

Date: *(mm/dd/yyyy)*: _____

Date of Birth: *(mm/dd/yyyy)*: _____ Age: ____ Gender: Female ___ Male ___

Mother's Name: _____ Father's Name: _____

Address: _____

City: _____ State/Province: _____ Zip/ Postal Code: _____

Phone # (Home): _____ Parents # Work: _____

Parent's E-mail Address: _____

How did you hear about Dr. Lord? _____

Who referred you? *(name)* _____ *(relationship)* _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y N
If yes, what?: _____

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PREVIOUS ILLNESSES

Tonsillitis	Y	N	German Measles	Y	N
- Approx. number _____			Chicken Pox	Y	N
Ear Infections	Y	N	Measles	Y	N
- Approx. number _____			Other	Y	N
Rheumatic Fever	Y	N	- List: _____		

Has your child had any of the following tests?

	When	Where
Electroencephalogram (EEG)	_____	_____
Psychological Evaluation	_____	_____
Hearing Tests	_____	_____
Speech/ Language Test	_____	_____

HOSPITALIZATION/ SURGERIES/ INJURIES

What hospitalizations, surgeries, or injuries has your child had?

_____
_____

IMMUNIZATIONS

Polio	Y	N	Pertussis	Y	N
Tetanus Shot	Y	N	Diptheria	Y	N
Measles/ Mumps/ Rubella	Y	N	Any adverse reactions	Y	N
Influenza	Y	N	If yes, what? _____		

ALLERGIES

Is your child hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmentals? _____
Breast fed? _____ How long? _____ Formula? _____ Milk/Soy _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins, or other supplements your child is taking:

1) _____ Dosage: _____
2) _____ Dosage: _____
3) _____ Dosage: _____
4) _____ Dosage: _____
5) _____ Dosage: _____
6) _____ Dosage: _____
7) _____ Dosage: _____
8) _____ Dosage: _____

REVIEW OF SYSTEMS

Y = Presently have N = Never had P = Significant problem in the past

Mental/ Emotional							
Mood swings	Y	N	P	Anxiety or nervousness	Y	N	P
Irritability	Y	N	P	Cries easily	Y	N	P
Hyperactivity	Y	N	P	Unusual fears	Y	N	P
Introvert / extrovert	Y	N	P	Sleep problems	Y	N	P
Motion / car sickness	Y	N	P	Nightmares			
Endocrine							
Heat/ cold intolerance	Y	N	P	Fatigue	Y	N	P
Excessive thirst	Y	N	P	Excessive hunger	Y	N	P
Low blood sugar	Y	N	P	High blood sugar	Y	N	P
Skin							
Rashes	Y	N	P	Eczema, Hives	Y	N	P
Acne, Boils	Y	N	P	Itching	Y	N	P
Head							
Headaches	Y	N	P	Head injury	Y	N	P
Dizzy spells	Y	N	P	High fevers	Y	N	P
Eyes							
Glasses or contacts	Y	N	P	Tearing or dryness	Y	N	P
Eye pain / strain	Y	N	P				
Ears							
Earaches	Y	N	P	Impaired hearing	Y	N	P
Nose and Sinuses							
Frequent colds	Y	N	P	Nose bleeds	Y	N	P
Stuffiness	Y	N	P	Hayfever	Y	N	P
Sinus problems	Y	N	P	Loss of smell	Y	N	P

				Mouth and Throat			
Frequent sore throat	Y	N	P	Canker sores	Y	N	P
Breath odor	Y	N	P				
				Neck			
Lumps	Y	N	P	Swollen glands	Y	N	P
Goiter	Y	N	P	Pain or stiffness	Y	N	P
				Respiratory			
Cough	Y	N	P	Wheezing	Y	N	P
Asthma	Y	N	P	Bronchitis	Y	N	P
				Cardiovascular			
Heart disease	Y	N	P	Murmurs	Y	N	P
				Gastrointestinal			
Belching / passing gas	Y	N	P	Stomach aches	Y	N	P
Constipation	Y	N	P	Diarrhea	Y	N	P
Bowel movements	How often: __						
				Urinary			
Frequent urination	Y	N	P	Bed wetting	Y	N	P
				Musculoskeletal			
Joint pain or stiffness	Y	N	P	Muscle spasms / cramps	Y	N	P
Broken bones	Y	N	P				
				Blood/ Peripheral Vascular			
Anemia	Y	N	P	Easy bleeding / bruising	Y	N	P

Is there any information about your child's health that you would like to add?

Welcome! We're honored to be of service to you and your child!

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