Pediatric Naturopathic Health Assessment

Name of Child: _____ D.O.B. ___/___/___ Age _____ ❑ M ❑ F Date: _____

Name of Mother: _____ Email: _____

Full Address: _____ Phone: _____

Name of Father: _____ Email: _____

Full Address: _____ Phone: _____

M.D. Name/Address: _____ Phone: _____

Living with ❑ Mother ❑ Father ❑ Guardian _____

Referral Source: _____

MAJOR HEALTH CONCERNS (IN ORDER OF IMPORTANCE)	**SINCE**	**CAUSE**
1.)		
2.)		
3.)		

Is there any condition, trauma, or incident after which your child has never been totally well again? ❑ No ❑ Yes; If so, what?

_____

_____

CURRENT MEDICATIONS/TREATMENTS/VITAMINS	**SINCE**	**CAUSE**

MAJOR INJURIES/SURGERIES/HOSPITALIZATIONS	**SINCE**	**CAUSE**

SYMPTOMS (Mark "N" for current symptoms and "P" for past symptoms)

__ Acne	__ Measles	__ Burning Urination	__ Nervous
__ Hives	__ Tonsilitis/Strep	__ Bloody Urine	__ Frequent Headaches
__ Hair Loss	__ Mumps	__ Anemia	__ Joint Pains
__ Eczema	__ Rheumatic Fever	__ Easy Bruising	__ Flat Feet
__ Chronic Rash	__ Scarlet Fever	__ Bleeding Tendency	__ Excessive Fatigue
__ Cradle Cap	__ Chicken Pox	__ Nosebleeds	__ Unusual Fears
__ Asthma	__ Ear Infections	__ Dizzy Spells	__ Cries Easily
__ Pneumonia	__ Thrush	__ Hearing Loss	__ Heart Murmur
__ Wheezing	__ Sinus Infections	__ Motion/Car Sickness	__ Sensitive to Light
__ Rubella	__ Frequent Urination		

IMMUNIZATIONS

__ Measles, Mumps, Rubella (MMR) __ Diphtheria, Pertussis, Tetanus (DPT) __ Small Pox

__ Influenza __ Polio __ Others_____

Any reactions to any of the above? ❑ No ❑ Yes; If so, which ones and what type of reaction was experienced? _____

_____

ALLERGIES

Has your child ever had allergies to or is now allergic to any of the following?

Drugs? ❑ No ❑ Yes; please specify: _____

Food? ❑ No ❑ Yes; please specify: _____

Other (please specify): _____

PRENATAL & BIRTH HISTORY

Full term, premature, late _____ Complications, if any _____

Length of labor _____ Vaginal or c-section _____

Child's birth weight _____ Anesthetics, drugs _____

Mother's age at conception _____

Any of the following problems for mother during the pregnancy?

__ Anemia
__ Spotting, Bleeding, Hemorrhage
__ Morning Sickness (1st trim)
__ Morning Sickness (2nd, 3rd trim)
__ Vaginal Infections
__ High Blood Sugar
__ High Blood Pressure
__ Varicose Veins
__ Thyroid Problems
__ Preeclampsia, Eclampsia
__ Excess Sugar Use
__ Excess Alcohol Use
__ Recreational Drug Use
__ Abortions/Miscarriages
__ Kidney and/or Bladder Infections
__ Emotional Trauma
__ Physical Trauma
__ Other _____

DEVELOPMENTAL HISTORY (if patient is less than 3 years old)

Any of the following problems during infancy?

__ Birth Defects
__ "Blue Baby"
__ Cerebral Palsy
__ Diarrhea/Constipation
__ Feeding Difficulties
__ Fever
__ Jaundice
__ Rashes
__ Seizures
__ Colic
__ Injuries
__ Other _____

Was child breastfed? ❑ No ❑ Yes; for how long?_____ Any problems? _____

Was child put on formula? ❑ No ❑ Yes; what kind? _____ Any problems? _____

Age at which solid foods introduced _____ Food introduced _____

Please indicate if there were any problems with the following and age when activity first started: **AGE**

Holding head up while on stomach _____ _____

Rolling from front to back and back to front _____ _____

Sitting with and without support _____ _____

Crawling _____ _____

Teething _____ _____

Talking (first word, combination of words, sentences) _____ _____

Walking with and without support _____ _____

Toilet training _____ _____

Any particular habits (thumb sucking, nail biting, head banging, rocking)_____ _____

Were there any nightmares, terrors, or sleepwalking? _____ _____

DENTAL HISTORY

Last Dental Exam: _____

Describe any dental work done: _____

What is the oral hygiene practice of the child? _____

Is your child's toothpaste fluoridated? ❑ No ❑ Yes

Does your child have bleeding gums? ❑ No ❑ Yes

VISION HISTORY

Last Vision Exam: _____

Describe any vision problems: _____

FAMILY HISTORY (Indicate maternal with "M" and paternal with "P")

__ Alcohol	__ Birth Defects	__ Heart Disease	__ Tuberculosis
__ Allergies/Hay fever	__ Cancer	__ High Blood Pressure	__ Other _____
__ Anemia	__ Diabetes	__ Kidney Disease	
__ Arthritis	__ Eczema	__ Mental Illness	
__ Asthma	__ Epilepsy/Seizures	__ Stroke	
__ Bleeding	__ Glaucoma	__ Thyroid (hyper/hypo)	

OVERALL HEALTH

Digestion

___ Weak appetite
___ Strong appetite
___ Body/breath odor
___ Excess gas
___ Abdominal pains
___ Vomiting
___ Canker sores
___ Bloating
___ Gas
___ Number of bowel movements a day
Color _____
Stool is: ___Formed ___ Loose
Stool is: ___ Hard to pass ___ Easy to pass
Stool: ___ Floats ___ Sinks

Other comments:_____

Sleep

___ Light
___ Deep
___ Lacking
___ Excess
___ Bedwetting
___ Night sweats
___ Difficulty falling asleep
___ Nightmares

Position:_____
Other comments:_____

Immune System

___ Good
___ Poor
___ Frequent colds/flus
___ Sore throats
___ High fevers
___ Chronic coughs

Other comments:_____

Mental Emotional Disposition

How does your child express the following emotions?

Anger_____

Sadness_____

Anxiety_____

Happiness_____

Fear_____

What fears does your child have_____

List major experiences of grief/loss in your child's life and how your child has coped with them: _____

_____

_____

_____

Please explain any other concerns you may have in regards to your child's health: _____

_____

_____

Food Plan Instructions:

Name:_____Date:_____

- Please record, in honesty, what your child eats for a few days. It will benefit you more to be real and not ideal!
- Include condiments, drinks, snacks, supplements (vitamins/minerals/herbs/homeopathic remedies).
- Include any comments, symptoms (emotional/mental/physical), energy levels, etc at the end of each column for each day.
- Be specific in your recordings by including what type of food is eaten ("white bread" or "whole wheat bread"), the quantity (cups, tsp, oz, etc), how it was prepared (baked, boiled, deep fried, etc) and the time of day it was eaten.

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

How many meals does your child generally eat each day? ❑One ❑Two ❑Three ❑More than three

How often does he/she skip meals? ❑Never ❑Once or twice a month ❑Once a week ❑More than once a week

Where is the food purchased? _____

_____

Who cooks the food? _____

_____

List foods excluded from the diet and why: _____

_____

_____

List any food cravings, regardless of their nutritional value: _____

_____

_____

List any foods which cause a bad reaction and what the reaction is: _____

_____

_____

Is your child thirsty? ❑ No ❑ Yes Amount of plain water drank each day: _____

_____

Type of water drank? ❑Distilled water ❑Filtered ❑Spring ❑Well ❑Deionized ❑Tap

At what temperature does your child prefer to drink liquids? ❑ Hot ❑ Cold ❑ Room temp

PEDIATRIC PATIENT INFORMED CONSENT

This Informed Consent is required by Minnesota Statute 147E in order that you, the patient, are aware of the nature of Stephani Waldron-Trapp, ND's practice in naturopathic medicine. The Minnesota Board of Medical Practice has required that each individual seeing Stephani Waldron-Trapp, ND read this form and sign it prior to consultation or treatment.

I, _____, UNDERSTAND THAT:

1. Stephani Waldron-Trapp, ND is fully credentialed and registered to practice naturopathic medicine in the State of Minnesota, pursuant to Minnesota Statute 147E. Her active registration number is 1016.

2. Dr. Waldron-Trapp received her four-year naturopathic medical training at University of Bridgeport College of Naturopathic Medicine, Connecticut, and graduated in 2005.

3. Dr. Waldron-Trapp passed all Naturopathic Physicians Licensing Examinations given by the North American Board of Naturopathic Examiners and received her Vermont license in 2005 to practice as a naturopathic doctor. She maintains this license as well.

4. Dr. Waldron-Trapp, to the best of her ability, will present treatment facts and options accurately, and will make recommendations according to standards of good naturopathic medical practice.

5. The scope of practice of a registered naturopathic doctor in the State of Minnesota includes, but is not limited to, the following services: (a) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, glandular, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; (b) performing or ordering physical examinations and physiological functions tests; (c) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA); (d) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results; (e) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; (f) prescribing or performing naturopathic physical medicine; and (g) admitting patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

6. A registered naturopathic doctor is **not** allowed to: (a) administer therapeutic ionizing radiation or radioactive substances; (b) administer general or spinal anesthesia; (c) prescribe, dispense, or administer legend drugs or controlled substances including chemotherapeutic substances; (d) perform or induce abortions; or (e) perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.

7. A registered naturopathic doctor is **not** allowed to practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietitian, nutritionist, or any other health care professional, unless the registered naturopathic doctor also holds the appropriate license or registration for the health care practice profession.

8. Potential risks include allergic reactions to prescribed herbs and supplements and side effects of natural medications.

9. All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

10. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Stephani Waldron-Trapp, ND or any of her personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand the statements above.

Patient Name: _____ Parent or Guardian Name: _____

Signature of Parent or Guardian: _____ Date: _____