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PEDIATRIC ADDITIONAL INFORMATION FORM

Child's First Name: _____ Last _____ Initial Visit Date _____

Birth date Mo. _____ Day _____ Year _____ Current Age _____

Pre-natal History:

Mother's info at conception: Height: _____ Weight: _____ General Health: _____ Age: _____

Father's info at conception: Height: _____ Weight: _____ General Health: _____ Age: _____

Please list any fertility issues (e.g. problems with conception, miscarriage, abortions, use of fertility drugs etc.):

How did Mother feel about the pregnancy (e.g. expected/ pleased/ frightened/ resentful/ happy)? _____

How did Father feel about the pregnancy (e.g. expected/ pleased/ frightened/ resentful/ happy)? _____

Mother's general health during pregnancy (circle one): Excellent Good Fair Poor ? Describe _____

How did the mother exercise throughout this child's pregnancy? _____

Weight gained during pregnancy: _____ Weight 3 mos. post-pregnancy _____

Please describe Mother's diet & cravings during pregnancy: _____

Nausea / vomiting during pregnancy: No Yes When, how long, and what were the triggers (food, scents, etc.)?

Medications / supplements taken during pregnancy: _____

Was there external stress at any time during the pregnancy at home? At work? Please explain. _____

Birth History:

Length of Pregnancy (weeks): _____

Child's Birth Weight: _____

Child's APGAR Test Scores: _____

Child's Birth Length: _____

Please describe any details of birth (vaginal birth/C-section, length of labor, epidural, forceps, vacuums, etc.):

Were medications used during labour and delivery? If yes, please list _____

Immediately after birth was there a support network for mother (midwives, family, breast feeding counselor etc.)?

Please explain situation: _____

Infant's History:

Was the child breast-fed?: Yes For how long? _____

No Why not? _____

Did Mother have any breast tenderness, insufficient supply, etc.? _____

Did baby have any difficulties breastfeeding (e.g. latching, disinterest, etc.)? _____

Was formula used? No Yes At what age? _____ Why? _____

What kind(s) & any reactions? _____

Food introduction: (please list the foods introduced, date introduced, and reactions (if any) to the food):

Food	Age	Reaction?	Food	Age	Reaction?	Food	Age	Reaction?
Milk			Wheat			Pop		
Yogurt			Chicken/Turkey			Chocolate		
Cheese			Red meat					
Rice cereal			Soy					
Pablum			Sugary foods					

What were the child's initial sleep patterns? When did they change? When did s/he start sleeping through the night?

Child's Home Environment (answer where applicable)

When was your home built? _____

Have you performed any renovations since the conception of this child (painting, plumbing etc.)? If so, when and how old was the child? _____

Do you have any pets? If so, please list and for how long: _____

Describe an average day in your home, for one weekday and one weekend (e.g. Are meals eaten together? Is one parent always busy working, etc.): _____

Is your child involved in any extracurricular activities? If so, please list: _____

How many hours does the child spend outdoors / week and where? _____

How many hours does each parent spend one-on-one with this child / week? Mom _____ Dad _____

Describe your child's personality (i.e. shy, outgoing, active, sedentary, responsible, perfectionist, competitive, affectionate, stand-offish etc.) _____

What tensions or stressful situations occur / have occurred at home in the child's life? _____

Describe the childcare resources in place for this child (i.e. babysitter, day home, family): _____

Developmental Milestones	Age Achieved	Typical Age Achieved
Sitting up		6 months
Crawling		9 months
Teething		12 months
Walking		12 months
Talking		9 months
Potty- trained		2 years

