Optimum Wellness
INTEGRATED CLINIC

Tel: 780 439-1200 Fax: 780 434-6800

CHILD INTAKE FORM

Name: _____Alberta Health Care #: _____

Address: _____

Street City Province Postal code

Parents E-mail: _____Cell : [____] _____ Work:[____] _____

Telephone: (home) [____] _____ Age: ___ Birth Date: M _____ D ___ Y_____ Sex: *M / F*

Parents Names: Mother - _____ Age - _____ Occupation - _____

Father - _____ Age - _____ Occupation - _____

Whom does the child live with? _____ Name of Medical Doctor: _____

Ethnic Background: _____ Religious Background: _____

How did you find out about our clinic? Who referred you? *Newspaper, Internet, Health food store, Friend, Another heath care practitioner* *Name:*_____

Has your child been treated by a Naturopathic Doctor before? *Y or N*

If 'yes', by whom? _____ When? _____

For what reason(s)? _____

In Case of Emergency:

Contact: _____ _____ [____] _____
Full name Relation Telephone

Signature: _____ Date: _____

List your child's health concerns and how long they have been occurring, in order of importance:

1._____

2._____

3._____

4._____

CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Patient: Please complete your child's questionnaire with care. Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. This is a confidential record of your child's medical history. It will not be released without your prior authorization.

Has your child had similar health concerns before? _____ Explain: _____

_____

Does your child have any relatives with similar problems? _____

What do you feel is causing the health problems your child may have? _____

_____

When did your child last feel well? _____

What long-term expectations do you as a parent have from working with this clinic? _____

_____

_____

What expectations do you have of me personally as your physician? _____

_____

_____

What behaviours or lifestyle habits does your child currently engage in regularly that you believe support his/her health? Please list.

_____

_____

_____

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self-destructive to their health? Please list.

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols that I will be sharing with you?

_____

_____

_____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes your child will be making?

_____

What is your present level of commitment to address any underlying causes of your child's health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

MEDICATIONS

How many times has your child been treated with antibiotics?_____ When was the last time?_____
Main reason for antibiotic use: □ Ear Infections □ Bronchitis □ Pneumonia □ Sinus Infection
□ Intestinal Infection □ Other (please explain)_____
Was your child ever treated for a yeast infection following antibiotic use _____

Please list all **"current"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** prescription medications

Medication	Date started [m/y]	Dose	Effectiveness

Please list all **"current"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

Please list all **"past"** vitamins, herbs, homeopathics, non-prescription, etc

Supplement / Vitamin (Brand Name)	Date started [m/y]	Dose	Effectiveness

HEALTH HISTORY

Does your child have any known contagious diseases at this time? *Y N* If yes, what?_____

How would you describe your child's current state of health? *Excellent Good Fair Poor*

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has had. Include approximate dates.

_____

_____

List any X-rays, CT scans, or other studies that your child has had.

_____

_____

Significant physical or emotional trauma: _____

Type of birth: □ Vaginal □ C-section

Allergies: Is your child sensitive or allergic to…

Any drugs?_____ Any environmentals?_____

Any chemicals?_____ Any supplements?_____

Any food allergies or intolerances?_____

Childhood Illnesses: (check those that apply) Which of the following conditions has your child had?

□ Asthma/Wheezing	□ Cradle cap	□ Frequent colds	□ Night sweats
□ Bedwetting	□ Cries easily	□ Frequent urination	□ Nose bleeds
□ Body/breath odor	□ Croup	□ Hair loss	□ Rubella
□ Burning of urine	□ Diaper rash	□ Heart disease	□ Seizures
□ Canker sores	□ Diarrhea	□ Heat intolerance	□ Sore throats
□ Change in appetite	□ Dizzy spells	□ High fevers	□ Stomach aches
□ Chicken pox	□ Easy bruising	□ Measles	□ Strep throat
□ Cold intolerance	□ Eczema	□ Mumps	□ Tonsillitis
□ Constipation	□ Fatigue	□ Nervous	□ Whooping cough

□ Unusual fears, describe:_____

□ Ear infections – How many and how often?_____

□ Other:_____

Immunizations: What immunizations has your child had?

□ DPT (diphtheria, pertussis, tetanus)	□ Hepatitis A	□ Flu shot
□ Haemophilus influenza B	□ Hepatitis B	□ Polio
□ MMR (measles, mumps, rubella)	□ Hepatitis C	□ Smallpox
□ Chicken pox	□ Other: _____	

Please indicate any adverse reactions your child has experienced from an immunization.

_____

_____

Digestive Health:

Does child have periodic loose stools/diarrhea? *Y / N*
Undigested food in stool? *Y / N*
Does your child suffer with reflux/heartburn? *Y / N*
Offensive Gas? *Y / N*
Is your child potty trained? *Y / N*
Bloating after eating? *Y / N*

Does your child produce formed stools? *Y / N*
Is your child currently taking an acid-blocking medication such as Losec, Pepcid, etc? *Y / N*
Did occurrence of digestive problems occur following a particular vaccine? *Y / N / Unsure*

Diet: Describe a typical day's diet.
Breakfast_____
Lunch_____
Supper_____
Snacks_____
How many cups/bottles/glasses does your child drink on average per day?

Beverage	Amount	Beverage	Amount	Beverage	Amount
Water		Fruit juice		Soft drinks regular	
Milk		Vegetable juice		Soft drinks diet	
Soy milk		Herbal Tea		Caffeine/energy drinks	

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.)? _____
_____

Feeding History:
□ Breast □ Bottle What kind of formula?_____ How long for either?:_____
Did your infant experience any reactions to formula or breast milk?_____
_____
Please list any foods that were introduced before 6 months, as well as any reactions noted:
_____
_____
What foods were introduced between 6 and 12 months? Were there any reactions to these foods?
_____
_____
Does your child have any cravings?_____
Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).
_____

Prenatal Health and History:
What was the health of the parents at the time of conception (please circle)?
Mother: *Poor Fair Good Excellent Unknown*
Father: *Poor Fair Good Excellent Unknown*
What was the health of the mother during pregnancy? *Poor Fair Good Excellent Unknown*

Emotional state during pregnancy? *Poor Fair Good Excellent Unknown*

On a scale of 1 - 10 (10 being highest), while pregnant, please rate your stress____ & energy levels____ .

Any new events/changes/symptoms/conditions in your life that occurred during pregnancy? *Y / N*

_____
How was the mother's diet during pregnancy? *Poor Fair Good Excellent Unknown*

Did the mother exercise during pregnancy? *Y / N* Type:_____Duration:_____Frequency:_____

What was the mother's age at the time of the child's birth?_____Occupation during pregnancy?_____

How many previous pregnancies _____and births_____?

Did the mother experience any of the following during pregnancy?
□ Bleeding □ High blood pressure □ Nausea □ Vomiting
□ Diabetes □ Thyroid problems □ Trauma □ Forced bed rest
□ Other:_____

Did the mother receive medical care during pregnancy and/or delivery? *Yes No Unknown.* If yes, why?

_____

Were any of the following interventions used during pregnancy?
□ Ultrasound □ Amniocentesis □ Chorionic villi sampling □ Triple Screen
□ Maternal serum screening □ Other:_____ _____

Did the mother use any of the following during pregnancy?

□ Tobacco □ Alcohol □ Recreational drugs:_____
□ Prescription medications (incl antibiotics):_____
□ Over-the-counter medications:_____
□ Vitamins and/or supplements:_____
Coffee: *Y / N* _____cups/d Soft drinks: *Y / N* _____cups/d Artificial sweeteners: *Y / N*
Did you consume dairy products? *Y / N*

Birth History: (please complete if your child is less than 2 years old)
Term length: □ Pre-term (37 weeks or less): ____ weeks □ Full-term (38-42 weeks): ____ weeks
□ Post-term (more than 42 weeks): _____ weeks
Location of birth: □ Hospital □ Home □ Birthing Center □ Midwife □Other:_____
Types of Intervention: □ Induction □ Forceps/suction □ Epidural/anesthesia □ Episiotomy
□ Other:_____
Were there any complications during delivery (e.g., breech, induction)?_____
_____
Length of labour: _____ Weight of infant at birth:_____Length of infant at birth:_____
APGAR score (0 to 10): 1minute _____ 2 minutes _____ 5 minutes:_____
Did the child experience any of the following at or shortly after birth?
□ Anemia □ Bradycardia □ Cyanosis □ Congenital defects:_____
□ Jaundice □ Rashes □ Seizures □ Birth injuries:_____
□ Infections:_____ □ Breathing difficulty:_____
□ Difficulties with feeding:_____ □ Colic:_____*mild*_____*moderate*_____*severe*
□ Birth defects:_____ □ Atrioventricular septal defect:_____
□ Other:_____
Please write any details pertaining to the birth experience that you feel are important to their well-being:
_____
_____

Developmental Milestones:
How was your child's health in the first year? ____ *Poor Fair Good Excellent Unknown*
How is your child's health now? *Poor Fair Good Excellent Unknown*
At what age did your child first: Sit up _____ Crawl _____ Walk _____ Talk _____
At what age did your child begin teething? _____ Were there any difficulties associated with it?
_____

Sleep Patterns:
What time does your child usually go to bed?_____ wake in the morning?_____
How many times does your child wake during the night?_____ Does your child wake rested? *Y / N*
Does your child nap? *Y / N* Length of nap:_____
Does your child have nightmares? *Y / N* Please describe (ie theme, how often)_____
Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, bed wetting, etc.)?
_____
_____

Social History:
Are parents divorced? *Y / N* Number of siblings (birth order):_____
Is your child in: □ school □ daycare □ home care □ other:_____
How would you describe your child's behaviour at school? _____
_____
How would you describe your child's behaviour at home?_____
_____
What are your child's interests and favourite activities? _____
_____
What recreational activities is your child involved in? ___ _____
_____

How would you describe your child's temperament/personality?_____
_____
Is there anything that you would want to change?_____
_____
_____
Does your child exercise regularly? *Y / N* Type, duration, frequency?_____
_____
How much television does your child watch? _____ hours a day/week
How often does your child play video games? _____ hours a day/week
How often does your child read (not for school) or How often does someone read to your child?
□ Daily □ Several times a week □ Weekly □ Less than weekly
Is there anything regarding this child that should not be mentioned in his/her presence?_____
_____
_____

Family History:
Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Condition	Relative(s)	Condition	Relative(s)	Condition	Relative(s)
□ Alcoholism		□ Depression		□ Learning disabilities	
□ Allergies		□ Diabetes		□ Mental Illness	
□ Anemia		□ Eczema		□ Multiple sclerosis	
□ Arthritis		□ Epilepsy		□ Muscular dystrophy	
□ Asthma		□ Glaucoma		□ Seizures	
□ Bed wetting		□ Heart disease		□ Stomach ulcers	
□ Birth defects		□ Hay Fever		□ Stroke	
□ Bleeding disorder		□ High Blood Pressure		□ Tuberculosis	
□ Cancer		□ Hyperactivity		□ Yeast infection	
□ Celiac disease		□ Juvenile Arthritis		□ Venereal disease	
□ Colitis		□ Kidney Disease		□ Other:_____	

□ I don't know the family medical history

Please fill in the following chart, based on the child's relatives:

Relation	Age (if living)	If deceased, at what age & cause of death?
Mother		
Father		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Sibling(s)		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		

Do either of the parents have a chronic illness? *Y / N* Please describe._____
_____
_____

Home Environment:
Are there any pets in the home? *Y / N* What type and how many?_____
_____
Does anyone in the child's household smoke? *Y / N*

Age of home _____ Carpet (age, type):_____ How is the child's home heated?_____

Lead paint (old home, age):_____ Is home located near a power line and/or cell phone tower? *Y / N*

Do you know of any toxins or other hazards that the child is regularly exposed to (home, hobbies, school, etc.)? Please describe._____
_____
_____
How would you describe the emotional climate of the child's home?_____
_____
_____
_____
Does your child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ___ _____
_____
_____

General Info:

Is there anything that you feel is important that has not been covered?_____
_____
_____
_____
_____
_____

Thank-you for your time and effort.
I look forward to working with you on your journey to health and well-being.

"*Those who do not find time every day for health must sacrifice a lot of time one day for illness.*"
-Father Sebastian Kneipp

CHILD CONSENT FORM

We would like to take this opportunity to welcome you to the Optimum Wellness Naturopathic Medical Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. We seek to improve your quality of life and health through natural means.

Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of an individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. At the Optimum Wellness Naturopathic Medical Clinic a thorough case history will be taken and a complaint oriented physical exam will be performed. We would also like to obtain recent blood tests (taken within the last 2 months). More specific examinations may also be required.

It is very important that you inform us immediately of any health concerns that your child has, if they are taking any medication (either prescription or over the counter drugs, supplements, herbs and/or homeopathic remedies). If the child's mother is pregnant, suspects she is pregnant or is breast-feeding, please advise us immediately.

There are some slight health risks to naturopathic medical treatment. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements, herbs and/or homeopathic remedies
- Pain, bruising or injury from intra-muscular injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

You understand that a record will be kept of health services provided. This record will be kept confidential and will not be released to others unless directed by yourself or unless law requires it. You understand that you may look at your child's medical record at anytime and can request a copy of it by paying the document fee of $25. You understand that information from your child's medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

_____
Initials

You understand that the Naturopathic Doctor will answer any questions that you have to the best of their ability. You understand that treatment results are not guaranteed. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures for your child, except for (please list any exceptions): _____.

_____
Initials

You intend this consent form to cover the entire course of treatment for your child's chief health concerns. You also confirm that you have the ability to accept or reject this care for your child of your own free will and choice. You also acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

_____
Initials

You understand that charges are to be paid at the time of the visit unless specific arrangements have been made prior to the scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____
Initials

You understand that you will be charged for any appointment that is missed or if you cancel with less than 48 hours notice.

_____
Initials

You will refrain from wearing scents/perfume due to the sensitivity of other patients.

_____
Initials

Patient Name: (Please Print) _____ Date: _____

Signature of Parent (if patient under 18 years of age): _____