Optimum Wellness
INTEGRATED CLINIC

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

CHILD INTAKE FORM

Name:				Alberta Health #:	
Address:					
City:		Province:		Postal Code:	
Cell Phone:		Home Phone:		Work Phone:	
Gender:		Age:		Birth Date: M/D/Y	
Parent's E-mail:					
Parent's 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 health care practitioner?*	Name:				
Has your child been treated by a Naturopathic Doctor before?				☐ Y	☐ N
If yes', by whom?		When?			
For what reason(s)?					
In Case of Emergency: Contact					
Full name:		Relation:		Phone No.:	

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 behaviours 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?	
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	Offensive Gas?	☐	Y	☐	N
Undigested food in stool?	☐	Y	☐	N	Is your child potty trainied?	☐	Y	☐	N
Does your child suffer with reflux/heartburn?	☐	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 check)?

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 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?	☐ Y	☐ N	☐ 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 Centre	☐ Midwife
☐ Other:			

Types of Intervention:

☐ Induction	☐ Forceps/suction	☐ Epidural/anesthesia	☐ Episiotomy
☐ Other:			

Were there any complications during delivery (e.g., breech)?					
Length of labour:		Weight of infant at birth:		Length of infant at birth:	
APGAR score (0 to 10): 1 minute		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:			☐ Birth defects:	
☐ Atrioventricular septal effect:			☐ Colic	☐ *mild* ☐ *moderate* ☐ *severe*
☐ 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?			
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		☐ Stoke	
☐ 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 below:

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?			

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, ets.)?

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 Integrated 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 Integrated Clinic, a thorough case history will be taken, and a complaint oriented physical exam may be performed. We would also like to obtain recent blood tests (taken within the last two months). More specific examinations may also be required.

It is 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

_____ Initials

You understand that a record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless so directed by yourself or unless law requires it. You understand that you may look at your child's medical record at any time and 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. You understand that health records may be shared with the nurses employed by Optimum Wellness Integrated Clinic.

_____ Initials

You understand that your naturopath 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 your scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____ Initials

You understand that you will be charged for the first appointment if it is missed or cancelled with less than 48 hours notice.

_____ Initials

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

Patient Name: (Please Print) _____ Date: _____

Signature: _____