Child's Profile for Naturopathic Visit

Child's Name: ________________________________ Age: _____ Date of birth: ___________ Sex: ____
(m / d / y)
Address: __________________________________ City: __________________ Postal code: ____________

Parent/Guardian contacts:
Mother's Name ____________________________ Phone: (H)_______________(W/Cell)________________

Father's Name ____________________________ Phone: (H)_______________(W/Cell)________________

Who referred you to us? ________________________________ Alberta Health Care No. ________________
(for file tracking purposes)
Family doctor ________________________________ Chiropractor __________________________________

Other practitioners in your child's health care team: ____

Email address (for policy, course info and health info updates) ______________________________________

A note to clients seeking naturopathic care for their children: Holistic, naturopathic and preventative health care are only possible when the doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionaire. Consider copying it for your own future records.

PRIMARY HEALTH CONCERNS:
In your opinion, what are your child's most important health concerns (chief complaints)?

Condition/complaint Diagnosed By: Since:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Which of the above problems are of most immediate concern to you as parents? ______________________

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated these health problems in your child? If you prefer, feel free to list these in chronological flow chart form on a separate page.

PRIOR TREATMENTS AND RESPONSE:

Please list all of the former treatments used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits your child received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan.

PRIOR DOCTOR-PATIENT RELATIONSHIPS

Please take a moment to reflect on your past relationships with your child's care providers and note how the relationships with future care providers could improve to optimize health care for your child. What do you need from your doctor that you have not received? How can you become more effective in supporting your child's health?

____

____

____

MEDICAL HISTORY

What childhood illnesses has your child had?

❍ Rubella (german/3 day measles)	❍ Measles (2 week)	❍ Mumps	❍ Chickenpox
❍ Whooping cough	❍ Polio	❍ Rheumatic fever	❍ Scarlet fever
❍ Roseola	❍ Asthma	❍ Mononucleosis	❍ _________________

	NOW	PAST	NEVER		NOW	PAST	NEVER
Anemia	❍	❍	❍	Diabetes	❍	❍	❍
Arthritis	❍	❍	❍	Hypoglycemia	❍	❍	❍
Asthma	❍	❍	❍	Allergies	❍	❍	❍
Bleeding	❍	❍	❍	Cradle cap	❍	❍	❍
Cancer	❍	❍	❍	Eczema	❍	❍	❍
Colic	❍	❍	❍	Ear infections	❍	❍	❍
Heart murmur	❍	❍	❍	Tonsillitis	❍	❍	❍
Mononucleosis	❍	❍	❍	Headache	❍	❍	❍
Injury (serious)	❍	❍	❍	Pneumonia	❍	❍	❍
Kidney disease	❍	❍	❍	Croup	❍	❍	❍
Liver dz./jaundice	❍	❍	❍	Hypothyroid	❍	❍	❍
Overweight	❍	❍	❍	Hyperthyroid	❍	❍	❍
Ulcers	❍	❍	❍	Strep throat	❍	❍	❍
Acne	❍	❍	❍	Hyperactivity	❍	❍	❍
Bed wetting	❍	❍	❍	Learning disorder	❍	❍	❍
Vomiting spells	❍	❍	❍	Impetigo	❍	❍	❍

Please list all diseases, surgeries, accidents or traumatic events your child has experienced:

Disease, Surgery, Accident, Trauma	Age	Duration	Recovery	Treatment including meds
____________________	_____	________	_________	______________________
____________________	_____	________	_________	______________________
____________________	_____	________	_________	______________________
____________________	_____	________	_________	______________________
____________________	_____	________	_________	______________________
____________________	_____	________	_________	______________________

SURGERIES: Tonsils, Adenoids, Ear tube insertion, Heart, Appendix, Hydrocele, Birth defect

ACCIDENTS: Any major accident or injury to the body or head, any occasion of unconsciousness, any hemorrhage or major bleeding from any part of the body.

TRAUMA: Any serious shock, grief, major disappointments, severe fright, nervous breakdown, period of stress overload.

MEDICATIONS - List your child's present medications including drugs, vitamins, minerals, homeopathics, herbs:

Drug/Nutrient:	Purpose:	Dose:	Taken since:

Is your child allergic to any medicines or other substance? If yes, please list:

___

What happens when your child has an allergy attack? ___

___

What prior types of allergy testing has your child had?

❍ Intradermal ❍ Scratch ❍ Blood IgG food ❍ Blood IgE inhalant/food ❍ Cytotoxic
❍ Electroacupuncture (VEGA, MORA) ❍ Kinesiology ❍ Food intolerance testing ❍ None

FAMILY HISTORY -

Are this child's parents: Married ____ Common-law ____ Separated ____ Divorced ____

Are there any brothers or sisters to this child?

Name	Age	State of health/health concerns

Please list ages and if deceased, what they died from and at what age.

Maternal Side	Paternal side
Mother ___	Father ___
Aunts/uncles ___	Aunts/uncles ___
Grandfather ___	Grandfather ___
Grandmother ___	Grandmother ___

Has any BLOOD RELATIVE had any of the following:

	YES	NO	UNSURE		YES	NO	UNSURE
Anemia	❍	❍	❍	Hay fever or allergies	❍	❍	❍
Arthritis	❍	❍	❍	Heart attack or disease	❍	❍	❍
Asthma	❍	❍	❍	High blood pr.	❍	❍	❍
Birth defects	❍	❍	❍	Mental illness	❍	❍	❍
Bleeding	❍	❍	❍	Seizure/epilepsy	❍	❍	❍
Cancer	❍	❍	❍	Sickle cell anemia	❍	❍	❍
Diabetes	❍	❍	❍	Stroke	❍	❍	❍
Eczema	❍	❍	❍	Thyroid (hyper/hypo)	❍	❍	❍
Glaucoma	❍	❍	❍	Tuberculosis	❍	❍	❍
Gout	❍	❍	❍	Venereal dz.	❍	❍	❍

Other (specify) ___ - specify ___

PRENATAL HISTORY

Describe mother's health during pregnancy with this child/infant/adolescent:

Mother's age when pregnant/delivery _______

	YES	NO	UNSURE		YES	NO	UNSURE
Bleeding	❍	❍	❍	Emotional stress	❍	❍	❍
Nausea	❍	❍	❍	Xrays	❍	❍	❍
Toxemia of pregnancy	❍	❍	❍	High blood pr.	❍	❍	❍
Trauma/injury pre birth	❍	❍	❍	Drugs/smoking/alcohol	❍	❍	❍

TERM: Full ___ Premature(how many days/weeks?)________ Late (how many days/weeks?)________

Was pregnancy easy?____ difficult?____

Was birth easy? ____ difficult?____________________________________Apgars_____________________

Place of birth: Hospital ____ Home ____ Clinic ____ Other _____________________________

FEEDING/DIET HISTORY

Breastfed? ____ How long? ____________________ Was it easy/difficult? ___________________________

Approximate feeding schedule ____

Formula? _____ How long?____________________ Combined with breastmilk? _______

Types of formula used and response to each type if adverse:

____

____

Age solid foods began _______ What foods? ____

Adverse reactions to introduced foods: ____

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

Where do you usually buy your food? ____

How much of your child's food is prepared by you? ____

List the primary foods included in your child's diet: ____

____

____

List the foods you exclude from your child's diet: ____

____

List any of the following (and relative amounts) eaten regularly by your child. Pop, caffeinated teas, highly seasoned foods, processed foods, refined foods and any food you suspect might be harmful to his/her health.

____

____

List any foods your child seems to crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): ____

____

List all the foods the child refuses to eat: ____

____

Is your child thirsty? ❍Yes ❍No Amount of liquid child drinks each day _________ Amt. plain water_____

What temperature liquid does the child prefer to drink? __ Hot __ Cold __Room temp.

Are you satisfied with your child's diet the way it is now? Why or why not? __________________________

____

VACCINATION HISTORY

Check off any that your child has received:

	X	When?	Boosters	X	When?	Describe any adverse reactions
DPT	___	__________		___	__________	___________________________________
Diptheria	___	__________		___	__________	___________________________________
Pertussis	___	__________		___	__________	___________________________________
Tetanus	___	__________	Tetanus booster?	___	__________	___________________________________
Measles	___	__________		___	__________	___________________________________
Mumps	___	__________		___	__________	___________________________________
Rubella	___	__________		___	__________	___________________________________
Polio	___	__________	Within past 2 yrs?	___	__________	___________________________________
Hepatitis	___	__________		___	__________	___________________________________
Hib	___	__________		___	__________	___________________________________
Influenza	___	__________	The last flu shot?	___	__________	___________________________________
Meningoc.	___	__________		___	__________	___________________________________
Chickenpox	___	__________		___	__________	___________________________________

Has your child been out of the country in the last 2 years? When? _____________ Where? _______________

Have you ever used homeopathics preventatively for infectious disease? ___________________

DENTAL HISTORY

Has your child been to see the dentist? ❍ Yes ❍ No

Describe any dental work done: ____

How many metallic fillings are present? ________ Have any been removed? ____________

What is the oral hygeine practice of the child? ____

Is your toothpaste fluoridated? ❍ Yes ❍ No

VISION HISTORY

Has the child's eyes been checked? ❍ Yes ❍ No

Describe any vision problems: ____

BOWEL/URINARY HABITS

Frequency of stool ____ times per day, ____ times per week

Does your child have pain passing stool? ____

Have you ever been concerned about a bowel habit that your child has displayed? _____________________

Any urinary symptoms that you are concerned about? ____

SLEEP - Does your child have trouble falling asleep? ❍ Yes ❍ No

What is the pattern of sleep? ____

Does your child sleep straight through the night? ❍ Yes ❍ No

Does your child wake looking/acting refreshed? ❍ Yes ❍ No

Does your child have recurring dreams or nightmares? ❍ Yes ❍ No

If yes, what is the theme? ____

What position does your child sleep in? ____

GENERAL STATUS

Listed below are factors which may or may not influence your child's state of being. Please mark the appropriate box signifying their influence on your child in general if applicable.

BETTER	WORSE		BETTER	WORSE	
❍	❍	Winter.	❍	❍	Spring.
❍	❍	Summer.	❍	❍	Autumn.
❍	❍	Cold.	❍	❍	Heat.
❍	❍	Dampness.	❍	❍	Storms.
❍	❍	Sun.	❍	❍	Wind.
❍	❍	Open air.	❍	❍	Confined (stuffy) air.
❍	❍	Change of weather.	❍	❍	Moonlight.
❍	❍	Ocean seashore.	❍	❍	Mountains.
❍	❍	Physical exertion.	❍	❍	Upon rising.
❍	❍	Morning.	❍	❍	Afternoon.
❍	❍	Evening.	❍	❍	Night.
❍	❍	Bath.	❍	❍	Cold applications.
❍	❍	Warm applications.	❍	❍	Travelling.
❍	❍	Touch.	❍	❍	Being consoled.
❍	❍	Presence of strangers.	______________________		Other.

Please mark (1)=mild, (2)=moderate, or (3)= severe next to the following symptoms which apply to your child NOW or in the PAST.

NOW	PAST		NOW	PAST	
____	____	Anxiety.	____	____	Memory difficulty, forgetting.
____	____	Restlessness.	____	____	Mental confusion.
____	____	Crying spells.	____	____	Decr. concentration, comprehension.
____	____	Depression.	____	____	Make many mistakes.
____	____	Despair/discontent.	____	____	Shy, timid.
____	____	Mood swings.	____	____	Critical of self.
____	____	Suicidal attempts.	____	____	Critical of others.
____	____	Loneliness/feel alone.	____	____	Lack of self-confidence.
____	____	Intimate with others.	____	____	Suspiciousness/jealous.
____	____	Prefer to be with company.	____	____	Sensitive to noises.
			____	____	Organized, neat/clean.
____	____	Prefer to be left alone don't seek out company.	____	____	Affectionate.
			____	____	Assertive, powerful.
____	____	Afraid when left alone.	____	____	Confident, secure.
____	____	Would rather be alone when not feeling well.			

Child's Development and Behavior

Is/Was your child's physical development: Slower than average Average Faster than average

Teething: Early ❍ Average ❍ Difficult ❍

Walking: Early ❍ Average ❍ Late ❍

Talking: Early❍ Average ❍ Late ❍

Mental/emotional development: Slower than average❍ Average❍ Faster than average ❍

How is your child's behavior/attitude and performance at school?

How is your child's behavior/attitude and performance at home?

Describe your child's social interaction with:
Siblings: ____
Other children: ____
Adults: ____
Strangers: ____

In a paragraph, write a short description of your child as he/she is currently. Include strengths, weaknesses, major personality characteristics.

Anger: What makes your child angry? ____
Does he/she get angry often/easily? ____
Does he/she experience uncontrollable rage? ____
Does he/she have difficulty expressing anger? ____
How does he/she express anger? ____

Sadness: What makes your child sad? ____
Does he/she cry when sad? ____
Does he/she cry easily/often? ____

Grief: List major experiences of grief/loss in your child's life.

Fears: Is your child fearful of anything such as: animals, snakes, rodents, people, being alone, robbers, ghosts, sudden noise, thunder, the unknown, heights, closed in spaces, failure, of doing new things, speaking in front of the class, being thrown up in the air and caught, falling, etc.? Are any unmanageable?

THANKS FOR YOUR CO-OPERATION, PATIENCE AND THOROUGHNESS!

INFORMED CONSENT for NATUROPATHIC SERVICES

Welcome to Resonance Wellness Inc. Resonance Wellness utilizes the principles and practice of Naturopathic Medicine to assist the body's own ability to heal and to improve the quality of life and health through natural interventions.

Your naturopathic doctor will conduct a thorough case history based on a review of your Initial Intake Form. Complaint specific physical exam, autonomic response testing (ART), laboratory testing of blood, saliva and/or urine may be used as part of the diagnostic work-up.

You will receive information about your diagnosis and/or treatment, including suggested courses of action, and expected benefits, risks and potential side-effects of treatments. Potential costs or additional requirements of such interventions will also be discussed. Treatment results are not guaranteed.

Treatments may include nutritional supplementation, dietary counseling, acupuncture, intravenous therapies, homeopathic medicines, and botanical medicines. Please be informed that it is your choice to purchase products directly from our dispensary or from another supplier. You may be referred for other evaluations or therapies as are applicable to your treatment plan. There are in-office paraprofessionals to whom you may be referred. Any practitioner at the clinic you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.
Payment is due at the time services are rendered. Payment can be made by cash, cheque, debit, Visa and or MasterCard. The current fee schedule for services is available online and at the front counter.

Cancellations less than 24 hours in advance may incur a fee.

Statement of Acknowledgement

I, ____________________________________ as a patient (or legal guardian of _________________________) of Resonance Wellness Inc., have read the above information and understand that my care will reflect the Philosophy, Principles and Practice of Naturopathic Medicine.

As Resonance Wellness Inc. is an integrated health clinic, I recognize that all the practitioners working with me will have access to my record. My record will be kept confidential and will not be released without my consent.

I also recognize that even the gentlest therapies potentially have complications in certain physiological conditions such as pregnancy or lactation or in very young children or those on multiple medications. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture, acupuncture or neural therapy; muscle strains and sprains, disc injuries from spinal manipulations and small risk of stroke with neck manipulation.

The information I have provided to Resonance Wellness is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements.

I am aware that I am free to withdraw my consent and to discontinue treatment at any time.

________________________________ ___________________ ______________________________

SIGNATUE DATE WITNESS

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