Natural Wellness

child patient under 8 years of age
confidential patient record
& health assessment

recent
patient photo

Date: _____

Child's Name: _____ (last name) (first) (initial) Address: _____ City: _____Province: _____Postal Code _____ Mother's Name: _____ (last name) (first) (initial) Father's Name: _____ (last name) (first) (initial)	Child's Age: _____ Date of Birth: / / month/ day /year □ male □ female Weight: _____ Height: _____
email - home phone - work phone - cell phone	
Who does the child live with? (both parents, mom, dad, grandparents etc):	
How did you find out about the Natural Wellness Centre?	

PRESENT CONCERN

What are your chief concerns about your child's health?

- _____
- _____
- _____

Who diagnosed the conditions noted above?

Specialist □ Family Doctor □ Other □ _____

What other concerns do you have about your child's health? :_____

_____

When was your child's last:

	Medical check-up.		Dental check-up
	Specialist consult: for		Optometrist eye check-up
	Counselor/Psychologist		other

Health History Overview

What was the level of health of both parents **prior to and at time of conception**?

Mother: Poor □ Fair □ Good □ Excellent □
Father: Poor □ Fair □ Good □ Excellent □

Did either parent use any of the following **prior to conception?** (circle if applicable)
Alcohol, drugs, smoking, other (please comment).

Mother's age at child's birth: _____

What was the level of health of the mother **during pregnancy**?

Poor □ Fair □ Good □ Excellent □
Comments: _____

_____

Did the mother use any of the following **during pregnancy**? (circle if applicable)
Alcohol, drugs, smoking, other (please comment). _____

_____

During the pregnancy, the mother experienced (please √ check the appropriate boxes):

	Bleeding		Hypertension		Thyroid Problems
	Nausea		Diabetes		Trauma (physical or emotional)
	Infection		Illnesses		Medications prescribed

List other drugs and medications the mother took during pregnancy:

Recreational: _____

Over the counter: _____

Prescription: _____

During the pregnancy the mother's diet was: Poor □ Fair □ Good □ Excellent □

Emotional state: □ Excellent □ Stable □ Stressed □ Very Stressed

Please check/comment on the following that apply regarding the pregnancy:

□ To Term □ Premature □ Late	Labour Duration □ 2 hours or less □ 2 to 6 hours □ 6 to 12 hrs □ More than 12 hrs □ Induced □ Natural progression	Degree of pain for mother: (low) 1-10 (high) scale:
Epidural □ General Anesthesia □	□ C-Section □ Vaginal Birth	Assistance: birth weight: □ Vacuum □ Forceps

Were there complications in the birth? No □ Yes □ Describe: _____

_____

Did your infant experience any of the following at birth or soon after? (please check)

□ Jaundice □ Colic □ Seizures □ Birth Defects □ Birth Injuries
□ Rashes □ Other: _____

Was the child breast-fed after birth? No □ Yes □ how many months? _____

Child's Health (first six months): Poor □ Fair □ Good □ Excellent □

Did your child have colic as a baby? Never □ Occasionally □ Often □ Severe □

Child's Sleep Patterns (first year): _____

Age your child began:
Sitting _____ Crawling _____ Walking _____ First Tooth _____First Words _____

Apart from water, breast milk or infant formula, what were the first liquids introduced?

_____

Age your child began eating solid foods: _____

Any solid foods introduced **prior to six months** of age?

Food	At What Month
_____	_____
_____	_____
_____	_____
_____	_____

Describe the basic introduction of other foods from **six to nine months** of age:

_____	_____
_____	_____
_____	_____

Does your child have any dietary restrictions (for any reasons)? _____

_____

Child's first illness that needed medical attention:

Illness: _____ Age: _____ Treatment: _____

What childhood illnesses has your child had?

Illnesses: √ Check if yes	Age	Comment if it was a severe case
Roseola (Red Measles) □ Rubella (German Measles) □ Chicken Pox □ Mumps □ Scarlet Fever □ Pertussis (Whooping Cough) □ Strep Throat □ Tonsillitis □ Ear Infections □ Pneumonia □ Rheumatic Fever □ Allergies □ Urinary Tract Infections □ Frequent Colds □ Impetigo □ Mononucleosis □ Tuberculosis □ Other _____ _____		

How many times has your child been treated with antibiotics?

□ Never □ 1 –5 times □ 6-15 times □ 16-25 times □ 25 or more times

Immunizations (√ check the ones your child has received):

□ Measles, Mumps, Rubella □ Diphtheria, Pertussis, Tetanus □ Polio
□ Influenza □ Pneumovax □ Hepatitis B

List all medications your child has taken that caused adverse reactions:

Age	Illness	Medication	Comment

List any current medicines your child is taking:

List any supplements or vitamins your child is taking:

Child's Diet:

3 or more meals per day? No □ Yes □

Any meals skipped? No □ Yes □

Late evening snacking? No □ Yes □

Favourite foods & snacks: _____

How much water every day (average): _____Litres

Other beverages: _____

Does your child sleep well each night? Never □ Rarely □ Mostly □ Always □

Does your child awake feeling rested and refreshed? Never □ Rarely □ Mostly □ Always □

Average number of hours your child sleeps each 24 hours _____

What are your observations of your child's temperament and personality? _____

_____

Was your child's physical development: □ slower □ average □ faster than average

Was your child's mental/emotional development: □ slower □ average □ faster than average

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

List your child's interests: _____

_____

Other activities is your child involved with? _____

_____

Electronics & Screen Time: Total hours per day of TV, computer, device, phone etc:

□ 0 □ 1 to 3 hours □ 4 to 6 hours □ 7 to 9 hours □ ten+ hrs

Systems Review: *Use √ (checkmark) if current. *Use ***P*** if past symptoms:

GENERAL			
	Unusual weight change		Weakness/Fatigue
	Fevers/Chills		Catches many 'seasonal' colds and flues

HEAD			
	Headache/ Head Pain		Head Injury/Trauma
	Dizziness		Lice Infestation
	Cradle Cap/Dandruff/Dry, Flaky Scalp		Sweating
	Hair Loss/Patchiness		Cold Temperature
SKIN			
	Rashes		Colour Change
	Eczema, Hives		Lumps
	Acne, Boils, Ulcers		Night Sweats
	Itching		Dry Skin
	Abnormal Temperature (Hot or Cold)		Moist Skin
	Nail Changes		Sun Burnt
	Chews Nails		Burns/Irritates Easily from Sun
EYES			
	Vision Problems		Eye Pain
	Glasses/Contacts		Tearing or Dryness
	Double Vision		Glaucoma
	Blurring		Eye Accident/Trauma
	Sensitive to Sun or Light		Itching
	Redness		Discharge
			Drooping Lids
EARS			
	Hearing Loss		Earache/Pain
	Dizziness		Ringing/Noises in Ears
	Discharge/Excessive Wax		Infections
NOSE and SINUSES			
	Colds or Flues		Nose Bleeds
	Stuffiness		Hay Fever
	Sinus Problems		Other Allergies
	Lost Sense of Smell		Pain in Nose or Sinuses
	Sore Face		
MOUTH and THROAT			
	Sore Throat		Sore Tongue/Mouth
	Gum Problems		Hoarse Voice, Loss of Voice
	Cavities		Loss of Taste
	Wants to Put Objects into Mouth		Craves Particular Food/Taste
	Mouth Discolouration (inside or out)		Mouth Odor
	Dry Mouth		
NECK			
	Lumps		Swollen Glands
	Pain or Stiffness		
RESPIRATORY			
	Wheezing		Sputum
	Cough		Spitting up of Blood
	Asthma		Bronchitis
	Emphysema		Pneumonia
	Pleurisy		Difficulty Breathing

	Pain on Breathing		Shortness of Breath at Night
	Tuberculosis		Shortness of Breath Lying Down
	Tuberculin Test		Snoring
	Sounds (sighing, whistling, rattling etc)		
CARDIOVASCULAR			
	Heart Disease		Murmurs
	High Blood Pressure		Chest Pain
	Rheumatic Fever		Cyanosis
	Palpitations, Fluttering, Missed Beat		Heart Tests
GASTROINTESTINAL			
	Diarrhea		Difficulty Swallowing
	Constipation		Colic
	Body/Breath Odor		Jaundice
	Change in Appetite		Change in Thirst
	Frequent Vomiting/ Nausea		Craves a Certain Food or Drink
	Stomach Aches		Belching or Passing Gas
	Liver Disease, Dysfunction		Blood in Stool
	Gall Bladder Disease, Dysfunction		Change in Stool
	Rectal Bleeding		Passing Undigested Food in Stool
	Hemorrhoids		Ulcer
	Abdominal Pain		Food Allergies, Sensitivities
	Hernias		Itchy/Burning Rectum
GENITOURINARY			
	Burning Urine		Pain on Urination
	Frequent Urination		Frequency at Night
	Bed Wetting		Inability to Hold Urine
	Blood in Urine		Urinary Tract Infection
	Urgency		Hesitancy
	Unusual Fears		Hernia
	Pain		Discharge
MUSCULOSKELETAL			
	Joint Pain or Stiffness		Growing Pain
	Arthritis/Joint Inflammation		Broken Bone
	Muscle Spasm, Cramp, Twitching		Weakness
	Back Pain		Orthotics, Braces, Supports
PERIPHERAL VASCULAR			
	Deep Leg Pain		Cold Hands/Feet
	Has Difficulty Warming Up		Extremity Numbness/Coldness
	Ulcerations on Skin		Bruises Easily
	Skin Discolourations, Patchiness		Tendency to Bleed
NEUROLOGIC			
	Fainting		Seizures/ Convulsions
	Muscle Weakness		Paralysis
	Memory Loss/Poor Memory		Numbness/Tingling
	Poor Balance		Involuntary Movement/Twitch
	Speech Problems		Dizziness
ENDOCRINE			
	Intolerance to Heat or Cold		Excessive Thirst

	Diabetes		Excessive Hunger
	Hypoglycemia		Excessive Urination
	Hormone Therapy		Excessive Sweating
BLOOD/LYMPHATIC			
	Anemia		Past Transfusion
	Lymph Node Swelling		Bleeds/Bruises Easily
	Nosebleeds		Infection Lasts a Long Time
ALLERGIES			
	Reaction to Past Immunization	Allergy/Sensitivity to:	
	Food		Pets, Animals
	Fabrics		Plants, Flowers
	Chemicals, Plastics		Hay, Weeds, Grasses
	Air, Environmental		Medication/Antibiotic
EMOTIONAL			
	Depression		Mood Swings
	Anxiety or Nervousness		Temper Tantrums
	Attention Deficit, Difficulty Concentrating		Unusual Fears
	Insomnia		Nightmares
	Sleep Problems		Cries Easily
	Irritable/Restless		Depressed
	Delusions/Hallucinations/Visions		Consumed in Thought/Fascination for Object or Idea

FAMILY HEALTH HISTORY

Indicate if there have been any of the following diseases in maternal **(MGM/MGF)** or paternal grandparents **(PGM/PGF)**, parents **(M/F)**, brothers **(B)** or sisters **(S)**.

	Diabetes		Cancer		Heart Disease
	Mental Illnesses		Alzheimer's Disease		Tuberculosis (TB)
	Arthritis		Hypertension		Allergies
	Thyroid problems, Goiter		Rheumatism		Kidney Disease
	Stomach Disorders		HIV/AIDS		Other
	Stroke		Mental/Physical Anomalies		

HOME LIFE

The child's natural parent's are:

□ Married □ Common Law □ Other □ Separated □ Divorced □ Remarried

Siblings? _____

Childcare: Who provides care for the child?_____

What is the present emotional climate of the child's home?

□Very Stable □ Stable □Stressful □Very Stressful

Environmental

Members of my household smoke: No □ Yes □ _____

Health impact concerns in the home due to:

	Poor air quality or filtration		Out-gassing building products		Animals, pets
	Carbon monoxide		Mold and mildew		Insects
	Radon or other gases		History of flooding		Rodents

FAMILY HEALTH HISTORY

Indicate if there have been any of the following diseases in **grandparents (G), parents (P), brothers (B) or sisters (S)**. *Also indicate the number of relatives who had the disease:

	Diabetes		Cancer		Heart Disease
	Mental Illness		Alzheimer's Disease		Tuberculosis
	Arthritis		Hypertension		Allergies
	Goiter		Rheumatism		Kidney Disease
	Stomach Disorders		HIV/AIDS		Other
	Stroke		Mental/Physical Anomalies		

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

_____

_____

_____

Thank you *for taking the time to fill out this information.*
This will help greatly in our study of your child's present health.

Next: complete the Covid19 Consent Form:

Covid19 Prevention & Safety Policy at Natural Wellness Centre

MANDATORY AGREEMENT between <u>all visitors and the Natural Wellness Centre</u>, under direction of Dr. T. R. Mrazek, ND at 1813 Halifax Street, Regina, SK.

During this time of COVID-19, extra measures for cleaning and social distancing are in place to protect all parties. These individuals include but are not limited to: patients and anyone accompanying them, including parents, caregivers and drivers, as well as the Naturopathic Doctor and the staff of the clinic.

A zero tolerance policy is in place regarding situations of higher risk transmission potential of Covid19.

<u>Requirements</u>

1. I will not attend if experiencing <u>any</u> of the following symptoms: sore throat, headache, fever, runny nose, sneezing or coughing.

2. I will not attend if I or someone in my household has tested positive for COVID-19, or have been tested but are still waiting for test results, or have been out of the province in the last 14 days.

3. Arrive on time to the appointment. Late arrivals, late cancellations and no-shows are still subject to charges as outlined in the clinic fees policy. There are no exceptions to this. Clinic fees are posted on the website under 'Appointments'

4. Wear a mask throughout the session, and removing of the mask only when directed by the ND. If you arrive without a mask, you will be issued one and charged $1.20 plus taxes. Failure to comply with mask requirements will terminate the session, with regular clinic fees being applied to the session. Clinic fees are posted on the website under 'Appointments'

5. Use hand sanitizer before each session. Sanitizer is provided at the clinic entrance.

6. Refrain from unnecessarily touching surfaces.

7. Maintain physical distancing whenever reasonable and possible.

As the (adult) patient, or the parent/guardian of a patient who is a minor, I hereby agree to the terms listed above.

Date: _____ Name (printed): _____

Signed: _____

Thank you for agreeing to these policies and protocols, which are in place to protect you as well as others. Your support and diligence help to keep us all safe!