

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

| recent  |       |  |
|---------|-------|--|
| patient | photo |  |

| Child's Name:   | :<br>(last name)                                | (first)  | (initial)                   | Child's Age:    |
|---|---|--|-----------------------------|-----------------|
|   |   |  | (IIIIIai)                   | Date of Birth:  |
|   |   | Province:Posta   | I Code                      |                 |
| Mother's Nam  | ie:   |  |                             | □ male □ female |
|   | (last name)                                     | (first)  | (initial)                   | Weight:         |
| Father's Nam  | e:  |  |                             |                 |
|   | (last name)                                     | (first)  | (initial)                   | Height:         |
|   |   |  |                             |                 |
|   |   |  |                             |                 |
|   | child live with? (bo                            | home phone<br>th parents, mom, dad, gra<br>atural Wellness Centre? | work phone indparents etc): | cell phone      |
| Who does the  | child live with? (bo                            | th parents, mom, dad, gra  |                             | cell phone      |
| Who does the  | child live with? (bo                            | th parents, mom, dad, gra  |                             | cell phone      |
| Who does the How did you f                                      | ind out about the N                             | th parents, mom, dad, gra  | ndparents etc):             | cell phone      |
| Who does the How did you f                                      | ind out about the N                             | th parents, mom, dad, gra  | ndparents etc):             | cell phone      |
| Who does the How did you f  RESENT C  /hat are you              | ind out about the N                             | th parents, mom, dad, gra<br>atural Wellness Centre?               | ndparents etc):             | cell phone      |
| Who does the How did you f  RESENT C  /hat are you              | ind out about the N                             | th parents, mom, dad, gra  | ndparents etc):             | cell phone      |
| Who does the How did you f  RESENT C  /hat are you              | ind out about the N  CONCERN  ur chief concerns | th parents, mom, dad, gra  | ndparents etc):             | cell phone      |
| Who does the How did you f  RESENT C  /hat are you              | ind out about the N                             | atural Wellness Centre?  s about your child's he                   | ndparents etc):             | cell phone      |
| Who does the How did you f  RESENT C  /hat are you  /ho diagnos | ind out about the N CONCERN ur chief concerns   | atural Wellness Centre?  s about your child's he                   | ndparents etc):             | ·               |

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? Fair 🗆 Good □ Mother: Poor □ Excellent Poor Father: 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? Fair □ Good □ Excellent Poor Comments:

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

Did the mother use any of the following **during pregnancy**? (circle if applicable)

Alcohol, drugs, smoking, other (please comment).

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

Emotional state: ☐ Excellent ☐ Stable ☐ Stressed ☐ Very Stressed

List other drugs and medications the mother took during pregnancy:

| List other drugs and medications the mother took during pregnancy.                               |
|--|
| Recreational:  |
| Over the counter:  |
| Prescription:  |
| During the pregnancy the mother's diet was: Poor $\Box$ Fair $\Box$ Good $\Box$ Excellent $\Box$ |

| Please check/comment of                                     | n the following that ap  | ply regarding th                   | ne pregnancy:              |
|---|--------------------------|------------------------------------|----------------------------|
| □ To Term   | Labour Duration          |                                    | Degree of pain for mother: |
| □ Premature   | ☐ 2 hours or less ☐ 2    | 2 to 6 hours                       | -                          |
| □ Late  | □ 6 to 12 hrs □ More     | than 12 hrs                        | (low) 1-10 (high) scale:   |
| General Anesthesia  |                          | Assis<br>□ Vac                     |                            |
| Were there complications                                    | in the birth? No □ Yes   | □ Describe:                        |                            |
| Did your infant experience  ☐ Jaundice ☐ Col ☐ Rashes ☐ Oth | lic 🗆 Seizures           | ☐ Birth Defects                    | s □ Birth Injuries ́       |
| Was the child breast-fed a                                  | after birth? No □        | Yes □ hov                          | w many months?             |
| Child's Health (first six mo                                | onths): Poor □ Fair □    | Good □ E                           | excellent □                |
| Did your child have colic a                                 | as a baby? Never □       | Occasionally □                     | Often □ Severe □           |
| Child's Sleep Patterns (firs                                | st year):                |                                    | <del></del>                |
| Age your child began: Sitting Crawlin                       | g Walking                | First Tooth _                      | First Words                |
| Apart from water, breast r                                  | nilk or infant formula,  | what were the f                    | first liquids introduced?  |
| Age your child began eati                                   | ng solid foods:          |                                    |                            |
| Any solid foods introduce<br>Food                           |                          | s of age?<br>At What Month<br>———— | I                          |
|   |                          |                                    |                            |
| Describe the basic introdu                                  | uction of other foods fr | om six to nine                     | months of age:             |
|   |                          |                                    |                            |

| Does your child have any dietary res                             | strictions (for any               | reasons)?                       |
|--|-----------------------------------|---------------------------------|
| Child's first illness that needed medi                           | cal attention:                    |                                 |
| Illness:   | Age:                              | Treatment:                      |
| What childhood illnesses has your c                              | hild 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  |                                   |                                 |
|  |                                   |                                 |
|  | a tracted with enti               | histian?                        |
| How many times has your child beer                               | n irealed with anii               | DIOUCS!                         |
| □ Never □ 1 –5 times □ 6-15 tir                                  | mes 🗆 16-25 time                  | s □ 25 or more times            |
| Immunizations (√ check the ones yo                               | ur child has recei                | (ed):                           |
| ☐ Measles, Mumps, Rubella ☐                                      |                                   | ,                               |
| • •  | Dipriliteria, Perius<br>Pneumovax | □ Hepatitis B                   |
|  | FIIEUIIIOVAX                      | □ Nepauus B                     |
| List all modications your shild has to                           | kan that agus ad a                | adverse reactions:              |
| List all medications your child has ta<br>Age Illness Medication | iken mai causeu a                 | Comment                         |
| - Insurance  |                                   |                                 |
|  |                                   |                                 |
|  |                                   |                                 |
|  |                                   |                                 |

| List any current medicines your child is tak         | king:   |
|--|---|
|  |   |
|  |   |
| List any supplements or vitamins your child          | ld is taking:                                   |
|  |   |
|  |   |
| Child's Diet:  |   |
| 3 or more meals per day? No $\square$                |   |
| Any meals skipped? No $\square$ Yes $\square$        |   |
| Late evening snacking? No □ Yes □                    |   |
| Favourite foods & snacks:                            |   |
| How much water every day (average): Other beverages: | <del></del>                                     |
| Does your child sleep well each night? Ne            | ever □ Rarely □ Mostly □ Always □               |
| Does your child awake feeling rested and i           | refreshed? Never □ Rarely □ Mostly □ Always □   |
| Average number of hours your child sleeps            | os each 24 hours                                |
| What are your observations of your child's           | s temperament and personality?                  |
|  |   |
| Was your child's physical development: □ :           | slower □ average □ faster than average          |
| Was your child's mental/emotional develop            | pment: □ slower □ average □ faster than average |
| How is your child's behavior and performal           | ance at school?                                 |
| List your child's interests:                         |   |
|  |   |
| Other activities is your child involved with?        | ?   |
|  |   |
| Electronics & Screen Time: Total hours pe            | er day of TV, computer, device, phone etc:      |
| •  | 6 hours □ 7 to 9 hours □ ten+ hrs               |

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

| GEN | ERAL                  |   |
|-----|-----------------------|---|
|     | Unusual weight change | Weakness/Fatigue                        |
|     | Fevers/Chills         | Catches many 'seasonal' colds and flues |
|     |                       |   |

| HEAD  Headache/ Head Pain  Dizziness  Cradle Cap/Dandruff/Dry, Flaky Scalp  Hair Loss/Patchiness  SKIN  Rashes  Eczema, Hives  Acne, Boils, Ulcers  Itching  Abnormal Temperature (Hot or Cold)  Nail Changes  Chew Nails  EYES  Vision Problems  Glasses/Contacts  Double Vision  Blurring  Sensitive to Sun or Light  Redness  Dizziness  Hearing Loss  Dizziness  Discharge  Dizziness  Discharge  Dizziness  Colds or Flues  Suns Problems  Colds or Flues  Sunsproblems  Colds or Flues  Sunsproblems  Colds or Flues  Sunsproblems  Colds or Flues  Sinus Problems  Colds or Flues  Colds or Flues  Sore Tace  MOUTH and THROAT  Sore Throat  Guny Author Cold  Nose Bleods  Pain in Nose or Sinuses  Dry Mouth  Neck  Lumps  Lice Infestation  Cough  Asthma  Bronchits  Lost Sene of Blood  Asthma  Bronchits  Frequency  Cough  Asthma  Bronchits  Peneumonia  Lice Infestation  Sweating  Cold Temperature  Lice Infestation  Cold Temperature  Loss of Temperature  Cough  Asthma  Bronchits  Penumonia   |                                 |                                 |
|--|---------------------------------|---------------------------------|
| Dizziness Cradle Cap/Dandruff/Dry, Flaky Scalp Cradle Cap/Dandruff/Dry, Flaky Scalp Cradle Cap/Dandruff/Dry, Flaky Scalp Hair Loss/Patchiness SKIN  Rashes Eczema, Hives Acne, Bolis, Ulcers Itching Abnormal Temperature (Hot or Cold) Nail Changes Chews Nails EYES  Vision Problems Glasses/Contacts Double Vision Blurring Redness Discharge Discharge/Excessive Wax Discharge/Facessive Wax Discharge Discharge Discharge Discharge Discharge/Excessive Wax Discharge Discharge/Excessive Wax Discharge/Excessive Wax Discharge Discharge/Excessive Wax Discharge/Excessive D |                                 |                                 |
| Cradle Cap/Dandruff/Dry, Flaky Scalp Hair Loss/Patchiness Cold Temperature  Cold Tem |                                 |                                 |
| Hair Loss/Patchiness   Color 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  |                                 |                                 |
| Rashes Eczema, Hives Lumps Acne, Boils, Ulcers Night Sweats Itching Abnormal Temperature (Hot or Cold) Nail Changes Usin Burns/Irritates Easily from Sun EYES Vision Problems Glasses/Contacts Double Vision Blurring Sensitive to Sun or Light Redness Discharge Discharge Discharge/Excessive Wax Discharge/Excessive Wax Infections NOSE and SINUSES Colds or Flues Stuffiness Sinus Problems Nose Face MOUTH and THROAT Gumps Washes Wants to Put Objects into Mouth Moist Skin Burns/Irritates Easily from Sun Eye Accident/Trauma Eye Pain Glaucoma Blurring Eye Pain Glaucoma Blurring Eye Accident/Trauma Eye Pain Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Eye Pain Eye Accident/Trauma Eye Accident/Traum |                                 | Cold Temperature                |
| Eczema, Hives Acne, Boils, Ulcers Iltching Dry Skin Abnormal Temperature (Hot or Cold) Moist Skin Nail Changes Chews Nails Burns/Irritates Easily from Sun EYES Vision Problems Glasses/Contacts Double Vision Blurring Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Blurring Redness Discharge Drooping Lids EARS Hearing Loss Earache/Pain Dizziness Dizziness Discharge/Excessive Wax Infections  NOSE and SINUSES Colds or Flues Sinus Problems Lost Sense of Smell Sore Face MOUTH and THROAT Gum Problems Most Markey Wants to Put Objects into Mouth Mouth Discolouration (inside or out) Dry Mouth NECK Lumps Pain or Stiffness RESPIRATORY Wheezing Sirus Problems Cough Asthma Emphysema Pineumonia Problemia Sputtum Sputtum Sputtum Mouth Discolouration Sputtum Sputtum Sputtum Sun Brookling Sputtum Sput |                                 |                                 |
| 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  |                                 |                                 |
| Itching  | •                               | Lumps                           |
| Abnormal Temperature (Hot or Cold) Nail Changes Sun Burnt Chews Nails Burns/Irritates Easily from Sun EYES  Vision Problems Glasses/Contacts Double Vision Glaucoma Blurring Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Eye Accident/Trauma Blurring Sensitive to Sun or Light Itching Redness Discharge Discharge  Hearing Loss EARS  Hearing Loss Ears Discharge/Excessive Wax Infections  NOSE and SINUSES Colds or Flues Sinus Problems Lost Sense of Smell Sore Face MOUTH and THROAT Sore Throat Gum Problems Cavities Wants to Put Objects into Mouth Mouth Discolouration (inside or out) NECK Lumps Pain or Stiffness Palm or Silfness Respiratory Wheezing Cough Asthma Emphysema Pneumonia Pneumonia   |                                 |                                 |
| Nail Changes   Burnst  |                                 |                                 |
| Chews Nails   Burns/Irritates Easily from Sun  |                                 |                                 |
| Vision Problems   Eye Pain   |                                 |                                 |
| Vision Problems   Eye Pain   |                                 | Burns/Irritates Easily from Sun |
| Glasses/Contacts Double Vision Glaucoma Blurring Eye Accident/Trauma Sensitive to Sun or Light Redness Discharge Drooping Lids EARS Hearing Loss Discharge/Excessive Wax Disch |                                 |                                 |
| 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) Dry Mouth NECK Lumps Swollen Glands Pain or Stiffness RESPIRATORY Wheezing Sputum Ernebums Bronchitis Emphysema Pneumonia  |                                 |                                 |
| Sensitive to Sun or Light Redness Discharge Drooping Lids  EARS Hearing Loss Bizziness Discharge/Excessive Wax Discharge/Pain Discharge Discharg | Double Vision                   |                                 |
| 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  |                                 |                                 |
| EARS  Hearing Loss Dizziness Discharge/Excessive Wax Discharge/Excessive Wax Discharge/Excessive Wax Discharge/Excessive Wax Infections  NOSE and SINUSES Colds or Flues Nose Bleeds Stuffiness Hay Fever Sinus Problems Dother Allergies Lost Sense of Smell Pain in Nose or Sinuses Sore Face MOUTH and THROAT Sore Throat Sore Throat Sore Throat Sore Throat Cavities Wants to Put Objects into Mouth Mouth Discolouration (inside or out) Dry Mouth NECK Lumps Pain or Stiffness Swollen Glands Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Bronchitis Emphysema Pneumonia  |                                 |                                 |
| EARS  Hearing Loss Dizziness Discharge/Excessive Wax Diffections  Nose Bleeds Hay Fever Diffections Diffections Nose Bleeds Diffections Diffections Diffections Diffections Diffections Nose Bleeds Diffections Di | Redness                         |                                 |
| Hearing Loss Dizziness Discharge/Excessive Wax Discharge/Pain Nose or Sinuses Discharge/Mouth Discharge/Excessive Wax Discharge/Excessive Wax Discharge/Pain Nose or Sinuses Discharge/Mouth Discharge/Boundary Discharge/Excessive Wax Discharge/Pain Infections Discharge/Pain |                                 | Drooping Lids                   |
| Dizziness Discharge/Excessive Wax Discharge/Excessive  | EARS                            |                                 |
| Discharge/Excessive Wax  NOSE and SINUSES  Colds or Flues Stuffiness Hay Fever Sinus Problems Lost Sense of Smell Pain in Nose or Sinuses  MOUTH and THROAT  Sore Throat Gum Problems Cavities Wants to Put Objects into Mouth Dry Mouth NECK Lumps Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Sore Mose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Sore Tongue/Mouth Pain in Nose or Sinuses Sore Tongue/Mouth Ctaves Particular Food/Taste Mouth Discolouration (inside or out) Mouth Odor Swollen Glands Sputum Sputum Sputum Spitting up of Blood Asthma Bronchitis Emphysema   | Hearing Loss                    | Earache/Pain                    |
| NOSE and SINUSES  Colds or Flues Stuffiness Hay Fever Sinus Problems Lost Sense of Smell Sore Face MOUTH and THROAT Sore Throat Gum Problems Hoarse Voice, Loss of Voice Cavities Wants to Put Objects into Mouth Mouth Discolouration (inside or out) Dry Mouth NECK Lumps Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Bronchitis Emphysema Nother Mose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nay Fever Nose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nose Bleeds Nay Fever Nose Bleeds Nay Fever Nose Bleeds  | Dizziness                       |                                 |
| Colds or Flues Stuffiness Hay Fever Sinus Problems Other Allergies Lost Sense of Smell Pain in Nose or Sinuses Sore Face MOUTH and THROAT Sore Throat Gum Problems Cavities Wants to Put Objects into Mouth Dry Mouth NECK Lumps Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Sinus Prever Other Allergies Pain in Nose or Sinuses Sore Tongue/Mouth Pain in Nose or Sinuses Sore Tongue/Mouth Craves Particular Food/Taste Mouth Odor Mouth Odor Swollen Glands Sputum Sputum Sputum Sputum Sputum Bronchitis Bronchitis   | Discharge/Excessive Wax         | Infections                      |
| Colds or Flues Stuffiness Hay Fever Sinus Problems Other Allergies Lost Sense of Smell Pain in Nose or Sinuses Sore Face MOUTH and THROAT Sore Throat Gum Problems Cavities Wants to Put Objects into Mouth Dry Mouth NECK Lumps Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Sinus Prever Other Allergies Pain in Nose or Sinuses Sore Tongue/Mouth Pain in Nose or Sinuses Sore Tongue/Mouth Craves Particular Food/Taste Mouth Odor Mouth Odor Swollen Glands Sputum Sputum Sputum Sputum Sputum Bronchitis Bronchitis   |                                 |                                 |
| Stuffiness 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  | NOSE and SINUSES                |                                 |
| Sinus Problems  Lost Sense of Smell  Sore Face  MOUTH and THROAT  Sore Throat  Gum Problems  Cavities  Wants to Put Objects into Mouth  Dry Mouth  NECK  Lumps  Pain or Stiffness  RESPIRATORY  Wheezing  Cough  Asthma  Emphysema  Other Allergies  Pain in Nose or Sinuses  Sore Tongue/Mouth  Loss of Tongue/Mouth  Hoarse Voice, Loss of Voice  Loss of Taste  Craves Particular Food/Taste  Mouth Odor  Mouth Odor  Swollen Glands  Sputum  Sputum  Sputum  Sputum  Pneumonia   |                                 |                                 |
| 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   |                                 | Hay Fever                       |
| Sore Face   MOUTH and THROAT   | Sinus Problems                  | Other Allergies                 |
| MOUTH and THROAT  Sore Throat  Gum Problems  Cavities  Wants to Put Objects into Mouth  NECK  Lumps Pain or Stiffness  RESPIRATORY  Wheezing  Cough Asthma  Emphysema  Sore Tongue/Mouth  Hoarse Voice, Loss of Voice  Loss of Taste  Loss of Taste  Mouth Odor  Craves Particular Food/Taste  Mouth Odor  Swollen Glands  Swollen Glands  Sputum  Sputum  Sputum  Bronchitis  Bronchitis  Pneumonia   | Lost Sense of Smell             | Pain in Nose or Sinuses         |
| Sore Throat Gum Problems Hoarse Voice, Loss of Voice Cavities Loss of Taste Wants to Put Objects into Mouth Mouth Discolouration (inside or out) Dry Mouth NECK Lumps Swollen Glands Pain or Stiffness RESPIRATORY Wheezing Cough Asthma Bronchitis Emphysema Sore Tongue/Mouth Hoarse Voice, Loss of Voice Loss of Taste  Loss of Taste  Sraves Particular Food/Taste  Mouth Odor  Swollen Glands  Swollen Glands  Spitting up of Blood  Spitting up of Blood  Pneumonia  | Sore Face                       |                                 |
| 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  | MOUTH and THROAT                |                                 |
| Cavities  Wants to Put Objects into Mouth  Mouth Discolouration (inside or out)  Dry Mouth  NECK  Lumps  Pain or Stiffness  RESPIRATORY  Wheezing  Cough  Asthma  Emphysema  Loss of Taste  Craves Particular Food/Taste  Mouth Odor  Swollen Glands  Swollen Glands  Sputum  Sputum  Sputum  Sputum  Pain of Blood  Asthma  Bronchitis  Pneumonia   | Sore Throat                     |                                 |
| Wants to Put Objects into Mouth  Mouth Discolouration (inside or out)  Dry Mouth  NECK  Lumps  Pain or Stiffness  RESPIRATORY  Wheezing  Cough  Asthma  Emphysema  Craves Particular Food/Taste  Mouth Odor  Swollen Glands  Swollen Glands  Sputum  Sputum  Sputum  Spitting up of Blood  Asthma  Bronchitis  Pneumonia   | Gum Problems                    | Hoarse Voice, Loss of Voice     |
| 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   |                                 |                                 |
| 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   | Wants to Put Objects into Mouth | Craves Particular Food/Taste    |
| NECK  Lumps Swollen Glands  Pain or Stiffness  RESPIRATORY  Wheezing Sputum  Cough Spitting up of Blood Asthma Bronchitis  Emphysema Pneumonia   |                                 | Mouth Odor                      |
| LumpsSwollen GlandsPain or StiffnessSpattanRESPIRATORYSputumWheezingSputumCoughSpitting up of BloodAsthmaBronchitisEmphysemaPneumonia  | Dry Mouth                       |                                 |
| Pain or Stiffness  RESPIRATORY  Wheezing Sputum  Cough Spitting up of Blood  Asthma Bronchitis  Emphysema Pneumonia  | NECK                            |                                 |
| RESPIRATORY Wheezing Sputum Cough Spitting up of Blood Asthma Bronchitis Emphysema Pneumonia   | Lumps                           | Swollen Glands                  |
| WheezingSputumCoughSpitting up of BloodAsthmaBronchitisEmphysemaPneumonia  | Pain or Stiffness               |                                 |
| WheezingSputumCoughSpitting up of BloodAsthmaBronchitisEmphysemaPneumonia  | RESPIRATORY                     |                                 |
| Cough Spitting up of Blood Asthma Bronchitis Emphysema Pneumonia   |                                 | Sputum                          |
| Asthma Bronchitis Emphysema Pneumonia  |                                 |                                 |
| Emphysema Pneumonia  |                                 |                                 |
|  |                                 |                                 |
| Pieurisy     Difficulty Breathing  | Pleurisy                        | Difficulty Breathing            |

| Pain on Breathing                         | Shortness of Breath at Night     |
|---|----------------------------------|
| Tuberculosis                              | Shortness of Breath Lying Down   |
| Tuberculin Test                           | Snoring Snoring                  |
| Sounds (sighing, whistling, rattling etc) | Gherring                         |
| CARDIOVASCULAR                            |                                  |
| Heart Disease                             | Murmurs                          |
| High Blood Pressure                       | Chest Pain                       |
| Rheumatic Fever                           | Cyanosis                         |
| Palpitations, Fluttering, Missed Beat     | Heart Tests                      |
| ,g,g,                                     |                                  |
| 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                       | 10                               |
| Deep Leg Pain                             | Cold Hands/Feet                  |
| Has Difficulty Warming Up                 | Extremity Numbness/Coldness      |
| Ulcerations on Skin                       | Bruises Easily                   |
| Skin Discolourations, Patchiness          | Tendency to Bleed                |
| NEUDOLOGIC                                |                                  |
| NEUROLOGIC                                | Coimmed Committee                |
| Fainting                                  | Seizures/ Convulsions            |
| Muscle Weakness                           | Paralysis Numbers (Tingling      |
| Memory Loss/Poor Memory                   | Numbness/Tingling                |
| Poor Balance                              | Involuntary Movement/Twitch      |
| Speech Problems                           | Dizziness                        |
| ENDOCRINE                                 |                                  |
| Intolerance to Heat or Cold               | Excessive Thirst                 |
| intolerance to neat of Cold               | EYCESSIVE THIISE                 |

| 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, Goite | er Rheumatism             | Kidney Disease    |
| Stomach Disorders       | HIV/AIDS                  | Other             |
| Stroke                  | Mental/Physical Anomalies |                   |

## **HOME LIFE**

| The child's natural | parent's are:                        |               |            |             |
|---------------------|--------------------------------------|---------------|------------|-------------|
| ☐ Married           | $\square$ Common Law $\square$ Other | □ Separated   | □ Divorced | □ Remarried |
| Siblings?           |                                      |               |            |             |
|                     | ovides care for the child?           |               |            |             |
| What is the preser  | nt emotional climate of the          | child's home? |            |             |
| □Very Stab          | le □ Stable                          | □Stre         | ssful □Ver | y 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     | Mol            | d and mildew               | Insects       |  |
| Radon or other ga   | ises Hist      | tory 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.

### Requirements

- 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!