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HEALTH EVALUATION FORM –
Child (infant -14 yrs)

Please take the time to thoroughly and thoughtfully complete your child's naturopathic health evaluation form and submit it back to the clinic 24 hours prior to their initial appointment. This information will be kept strictly confidential.

*Today's date:*_______________

Child's name: ________________________________ Sex: M / F Age ____

Date of birth (day/month/year) ____________________

Address ______________________________ City ______________ Postal Code______________

Parent/Guardian name(s) ____

Address (if different from child's) ____________________ City ______________ Postal Code______________

Phone (Home) (______)________________ (Work) (___)______________ Cell (____)________________

Okay to leave a message? Yes / No Which number? __________________

Email ______________________________

Siblings (names & ages) ____

How was this child referred to our office? ____

Family Doctor/Pediatrician

Name: ______________________________ Phone (_____)__________ Fax (______)__________

Address ____

Date of last visit:__________Findings of concern?____

Midwife/Obstetrician (child under 2)

Name: ______________________________ Phone (_____)__________ Fax (______)__________

Address ____

Date of last visit:__________Findings of concern?____

What is your child's chief health concern?

1.____

____

Date of onset of this concern:____

What treatments are you currently trying and what are the results?____________________________

____

What treatments have you tried in the past and what were the results?_______________________

____

____

What are your child's other health concerns?

2. ____ Date of onset: ______________

3. ____ Date of onset: ______________

4. ____ Date of onset: ______________

5. ____ Date of onset: ______________

Have the above condition(s) been diagnosed by a health practitioner? Y / N If Yes, by whom?__________

____

Does your child receive an annual physical exam or well-child check-up? Yes / No From: __________________

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

CHILD'S HEALTH HISTORY

Allergies: ____

Hospitalizations: hospitalized? (Reasons and dates): _____________________________________

____

Development: at what age did your child begin: teething__________ sitting ________ crawling ________
walking _______ talking _________ potty training _________ Were there any problems or concerns at any of these stages?____

Please indicate whether your has experienced any of the following conditions:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Coordination problems		Whooping cough	
Learning difficulties		Behaviour problems		Eating problems		Other	

If other, please describe: ____

Is there any condition from which you feel your child has never been well since? ____________________

____

IMMUNIZATION HISTORY

Please indicate immunizations and approximate dates:
Measles, Mumps, Rubella (MMR): ____________ Polio: _____________ Diphtheria, Pertussis, Tetanus (DPT): _______
Haemophilus Influenza B (HIB): ____________Hepatitis B: ______________________________Hepatitis A: ____________
TB: ____________________ Chicken Pox: ___ HPV (Gardasil): _______________________ Pneumovaccine: ______
Flu: _________________________________ Other:____
____ Any adverse reactions following vaccination?

Fever		Excessive crying		Pain/Swelling		Behaviour Changes	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please describe: ____

MEDICATION HISTORY

Please list all PAST and CURRENT over-the-counter and prescription medications, supplements etc.:

Taking CURRENTLY:	**Dose**	**Dates of Use**	**Taken in the PAST:**	**Dose**	**Dates of use**

FAMILY HISTORY

Relative:	**Age if Living:**	**Health Conditions:**	**Age at Death:**	**Cause of Death:**
Mother				
Father				
Sister(s)				
Brother(s)				
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Other blood relatives with notable health conditions (i.e. Cancer, heart disease, stroke, mental illness, etc.)				

Please indicate whether any blood **relatives** have experienced the following conditions:

Allergies		Anxiety		Asthma		Autoimmune disease	
Birth defects		Bleeding disorder		Anemia		Deafness	
Depression		Diabetes		Eczema		Heart attack/disease	
Hepatitis		Venereal disease		HIV/AIDS		High blood pressure	
Kidney disease		Mental illness		Peptic Ulcer		Cancer	
Tuberculosis		Visual problems		Arthritis		Cataracts	
Stroke		Hypoglycemia		Thyroid disease		Other	

If other, please describe: ____

PERINATAL HISTORY

Parents' health at time of conception: Mom: excellent / good / fair / poor / unknown
Dad: excellent / good / fair / poor / unknown
Parents' age at time of conception: Mom: __________ Dad: _________ **Was** the pregnancy planned? ____________________
How was the mother's overall health during the pregnancy? excellent / good / fair / poor / unknown
How was the mother's diet during the pregnancy? excellent / good / fair / poor / unknown
What was the mother's level and type of exercise during the pregnancy?______________________________

How would you describe the pregnancy? ____
____

Please indicate any health conditions mom experienced during the pregnancy:

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
German Measles		Venereal disease		High blood pressure		Infection	
Nausea/Vomiting		Physical trauma		Anxiety/Fear		Thyroid Problems	
Bleeding		Weight gain/loss		Depression		Other	

If other, please describe: ____
Medications (over-the counter and prescription), vitamins, supplements etc. taken during the pregnancy:_________ _
____

Please indicate the mother's use of/exposure to the following during the pregnancy?

Tobacco: Y / N How much, how often? ___________Second-hand smoke: Y / N How much, how often? _________
Alcohol: Y / N How much, how often? ______________Caffeine: Y / N how much, how often? ____________________
Recreational Drugs: Y / N Which one(s)?______________How much, how often? ___________________________
Please describe any emotional traumas during the pregnancy? ______________________________
____
Had there been any history of complications with a previous pregnancy?______________________________
____
Duration of pregnancy? __________wks Early?___________________days _______wks Late? ______days ____ wks Duration of prelabour? _________________ Duration of active labour? ______________________ Was labour spontaneous? Y / N If no, how was labour induced?__ ______________________________ Type of delivery? Vaginal ________________ C-section ___________________________ Emergency c-section _________
Location of delivery? Home _ Hospital ___ Birthing Centre ___ Other _______________________
Parties present for birth: ____
Any interventions used? Anesthesia ____ Epidural _______ Episiotomy ________ Forceps ______
Vacuum _______ Other __________
Weight at birth: __________ Length at birth: ___________
APGAR scores: 1 minute: ____________ 2 minutes: ____________ 5 minutes: ____________
Interventions performed at or soon after birth: Incubation __________ Medication __________________________
Respirator _________ Surgery __________ Bili-lights ________ Other _______________________________

Please indicate whether any of the following conditions occurred at or soon after your child's birth:

Allergic reaction		Birth defects		Feeding difficulty		Jaundice	
Fever		Failure to thrive		Hypoxia		Colic	
Infection		Rash		Respiratory difficulty		Seizure	
Unusual Wt. Changes		Other					

If other, please describe:____

How was the mother's physical and emotional health during the postpartum/recovery ?

____

NUTRITIONAL HISTORY

Was your child breastfed? Y / N If yes, for how long? ____________________

Any difficulties with breastfeeding?____

What type and brand of infant formula, if any, was used? ____________________
What was the first liquid introduced to your child after breastmilk or formula? ____________________
How would you describe your child's eating habits? ____________________

____

Is your child a vegetarian? Y / N Any food aversions?__________ Any food cravings?__________

Please list the solid foods introduced prior to 12 months of age, and any reactions noted:

FOOD	AGE OF INTRODUCTION	RESPONSE/REACTION

Please outline your child's typical daily food intake:

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

Water intake: ____________________Other fluid intake:____________________

SOCIAL HISTORY

How would you describe your child's temperament? ______________________________

How does your child interact with other children? ______________________________
With adults? ______________________________
Please indicate any emotional traumas your child has experienced: ______________________________

How does your child handle stress? ______________________________

How does your child express emotions? ______________________________

How is your child's performance in school? ______________________________

Have any behavioral or learning problems been noted? ______________________________

What are your child's favorite activities? ______________________________

How much physical activity does your child get? ______________________________

Does your child sleep through the night? Y / N Bedtime: ________ Wake time:______ # of hours' sleep/night:______
Naps: ______________________________ Bad dreams or nightmares? Y / N

Have you observed any of the following during your child's sleep? sleepwalking / talking / laughing / shouting / moaning / teeth grinding / twitching / perspiration / other ______________________________

Which countries outside Canada has your child travelled to? ______________________________

HOME ENVIRONMENT

How many people live in your home? ________ Pets in the home? ______________ Potential allergens? (e.g. mould, dusts, etc)?________________Seatbelt or child car seat use? ____________________
Approx. age of home? ______________________ How is your home heated? ______________________
Stress level in the home (1 to 10) ________________
Is your child exposed to: Smokers? ______Alcohol or drug abusers?____________ Physical, verbal or sexual abuse? ____________ Unsafe neighborhood? __________ Toxins? (e.g. lead, new carpet, etc.) ____________
How would you describe the emotional climate in the household? ______________________________

Is there anything else you feel may be important and would like to add? ______________________________

Thank you for taking the time to complete this detailed questionnaire. The information you've provided here is kept confidential and will be a valuable resource for us as we work together to create an individualized plan for optimizing your child's health, both today and in the long run. Looking forward to meeting with you soon!

INFORMED CONSENT TO THE TREATMENT OF A CHILD

Please note that this form must be signed in my office prior to the rendering of any treatment or service.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors are regulated primary health care providers who assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non--invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor (ND) will take a thorough case history, perform a physical examination and may order blood and urine testing. If your child's case requires, the physical may include more specific examinations such as gynecological, breast, rectal, or genital exams.

It is very important that you inform your Naturopathic Doctor immediately of any illness from which your child is suffering and any medications/over--the--counter drugs that he/she is taking. With your child as a patient you will receive information about his/her diagnosis and/or treatment, alternative courses of action, costs, and expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to: Homeopathic remedies may occasionally result in the aggravation of pre--existing symptoms. When this occurs the duration is usually short. Some patients may experience allergic reactions to supplements and herbs. Please advise your ND of any known or suspected allergies. Pain, bruising or injury from acupuncture; fainting or puncturing of an organ with acupuncture needles. Your ND is trained to handle emergencies should the need arise.

As the parent/guardian of ____ , I understand and agree:
(Name of child}

--That _________________________ ND, Healing Foundations Naturopathic Clinic do not guarantee treatment results.
--To take responsibility for the fees incurred in the naturopathic treatment of this child. --That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
--That I am free to withdraw my consent in full or in part, and to discontinue treatment at any time.

We believe in staying connected with you by sending a monthly e-newsletter, which provides practical, safe and effective health tips on how to naturally care for yourself and loved ones - includes health related articles written by your ND's and osteopathic practitioner, current research on health related topics that matter to you and clinic news and information.

- ❑ Check here if you prefer to NOT receive this kind of contact from us.

____________________	____________________	____________
Signature of Parent/Guardian	**Print Name**	**Date**

Witnessed by:

____________________	, ND ____________________	____________
Signature of Attending ND	**Print Name**	**Date**

PRIVACY POLICY

Privacy of personal information is important at the Healing Foundations Naturopathic (hereafter: “the clinic”). In providing your child with quality naturopathic care, we are committed to collecting, using and disclosing personal information responsibly. We strive to be as transparent as possible about the way we handle your child’s personal information.

In this office, ______________________________ acts as the privacy officer.

To help you understand how we are protecting your information, we have outlined how the clinic is using and disclosing your information.

Your child’s information will be disclosed for the following purposes:

- ✓ To assess his/her health concerns
- ✓ To provide health care
- ✓ To advise you of treatment options
- ✓ To establish and maintain contact with you
- ✓ To send you newsletters and other information mailings
- ✓ To remind you of upcoming appointments
- ✓ To communicate with other health-care providers
- ✓ To allow us to efficiently follow-up for treatment, care and billing
- ✓ To complete claims for insurance purposes
- ✓ To invoice for goods and services
- ✓ To process credit card payments
- ✓ To collect unpaid accounts
- ✓ To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others
- ✓ To use for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information).

Your and your child’s identity will be protected at all times and if necessary, identifying information will be altered to protect to your privacy in all the above instances.

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your child’s personal information as outlined above.

PATIENT CONSENT TO THE COLLECTION AND USE OF PERSONAL INFORMATION:

I, (***name of parent or guardian:***)__________________________________ have reviewed the above information that explains how the clinic will use my child’s personal information. I agree that the clinic can collect, use and disclose personal information about my child, (***name of child:***)

__________________________________ as set out in the clinic’s privacy policy, described above.

__________________________________ __________________________________ ____________________

Signature of Parent/Guardian **Print Name** **Date**