CONFIDENTIAL CHILDREN'S HEALTH AND LIFESTYLE INTAKE FORM

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Dear Patient, Parent or Guardian:
Please complete this form with care. Your answers will help me determine the most effective care. Please print throughout. Any questions that you would rather discuss in person can be marked-off for discussion. I appreciate you taking the time to fill this in prior to our visit. Please bring this completed form with you when you come. Thank you.

PT#:_____

PATIENT INFORMATION

CONSULTATION DATE:_____

NAME:_____ AGE:____ DATE OF BIRTH:_____

ADDRESS:_____ CITY: _____POSTAL CODE_____

PHONE _____ WORK PHONE _____EMERGENCY PHONE _____

PARENT'S/GUARDIAN'S NAMES: MOTHER _____ FATHER _____

SCHOOL YEAR: _____

GENERAL INFORMATION

Height _____ weight _____ weight one year ago _____
Do you exercise regularly? _____how often? _____ What type? _____
What are your hobbies, skills, interests, and/or favourite pastimes?

How would you generally describe your current health?

ALLERGIES OR SENSITIVITIES

DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES? If yes, please list them. Examples: drugs, foods, environmental? Which medicines (including herbal) have you taken for them? When and where are your allergies least and most troublesome? What has most helped your allergies?

MAIN REASON FOR VISIT

WHAT IS THE MAJOR HEALTH CONCERN THAT HAS BROUGHT YOU TO THIS OFFICE?
Please describe all the symptoms in as much detail as possible. Has there been a western medical diagnosis? When did the symptoms first begin? Are they getting worse? What makes it worse or better? How severe are the symptoms? What is the timing, frequency, duration of symptoms? Is there a pattern to the symptoms? What is the relationship between various symptoms? (Please include any significant lab reports):

ARE YOU CURRENTLY ON ANY MEDICATION(S), PRESCRIPTION, TREATMENTS OR OTHERWISE? _____
Example: laxatives, cortisone, pain relievers, tranquillisers, thyroid medication, hypotensive drugs, etc. or other treatments or therapies. if yes, please list them and give dosage. What are the results of the treatment(s):

ARE YOU CURRENTLY TAKING ANY NUTRITIONAL SUPPLEMENTS, VITAMINS, MINERALS OR OTHER HEALTH PRODUCTS? If yes, please list them and the dosage:

ARE YOU CURRENTLY SEEING ANY OTHER HEALTH CARE PROFESSIONALS? YES _____ NO _____
Give the name(s) of health care professional(s) and what they do:

HEALTH HISTORY

PLEASE CHECK ANY OF THE BELOW SYMPTOMS OR DISEASES YOU HAVE EXPERIENCED. Use a scale of 1-5, **1** the least and, **5** being the most severe. If unsure, use a question mark '**?**'.

____AD(H)D	____AIDS	____Allergies
____Anaemia	____Anxiety	____Asthma
____Bloating	____Cancer	____Chemical sensitivities
____Common cold	____Constipation	____Depression
____Diabetes	____Diarrhoea	____Dizziness
____Environmental sensitivities	____Epilepsy	____Epstein-Barr virus
____Excess stress	____Eyesight problems	____Fatigue
____Headaches	____Hearing problems	____Heart problems
____Hepatitis A, B, or C	____HIV	____Hyperglycaemia
____Hypoglycaemia	____Immune disorders	____Injuries
____Numbness	____Rashes	____Respiratory problems
____Seizures	____Shingles	____Shortness of breath
____Sleep problems	____Sore throats	____Stiffness
____Stomach aches	____Swellings	____Tumours
____Urinary tract infections	____Earaches/infections	____Enlarged adenoids

Other:

PREVIOUS MEDICATIONS AND TREATMENTS

HAVE YOU EVER BEEN HOSPITALIZED, HAD ANY OPERATIONS OR ACCIDENTS INCLUDING AUTOMOBILE? Please give the dates and reasons.

HAVE YOU HAD ANY DIAGNOSTIC TESTS OR PROCEDURES OVER THE PAST 2 YEARS? Example: x-rays, cat scans, MRI, blood tests, etc. If yes, please list dates and results.

IMMUNIZATIONS

Please give dates if possible:

polio _____ tetanus / whooping cough / diphtheria _____

flu shot _____ measles / mumps / rubella _____

Other_____

IMMUNE SYSTEM

Please mark '**P**' for previous condition, '**C**' for current and '**?**' if unsure.

____Adenitis ____Allergies ____Autoimmune disorders

____Catch everything ____Heal slowly ____Infections

____Low grade fever ____Lowered resistance _____Sore throats

____Swollen lymph glands

Do you have any concerns about your immune system?

CHILDHOOD ILLNESSES, DISEASES AND SYNDROMES

____Allergies ____Asthma ____Atopic eczema ____Bronchitis

____Chicken pox ____ Ear infections ____German measles (Rubella)

____Measles ____Mononucleosis ____Mumps ____Rheumatic fever

____Tonsillitis ____Whooping cough (Pertussis) Other_____

FAMILY MEDICAL HISTORY

PLEASE NOTE MEDICAL PROBLEMS OF CLOSE FAMILY MEMBERS: (children, sisters, brothers, grandparents, aunts and uncles) For example cancer, diabetes, heart disease, high blood pressure, stroke, epilepsy, mental illness, asthma, hay fever, eczema, anaemia, glaucoma, kidney disease, etc.

Member	Age	Health problem (if deceased, age at death and cause of death)_____
Father	_____	_____
Mother	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENERAL HEALTH

ENERGY LEVELS

Are you satisfied with your energy levels? Please describe:

EMOTIONAL

Use a scale of **1** (rare) to **5** (very common) on the below conditions if they are pertinent to you

____Angry ____Anxious ____Attentive

____Bi-polar ____Depressed ____Dreamy

____Enthusiastic ____Fearful ____Forgetful

____Grumpy ____Happy ____Inspired

____Lethargic ____Manic ____Nervous

____Sad ____Think a lot ____Worry

Other_____

How would you describe your emotional health?

CONCENTRATION

How is your concentration? Has it changed? If so, when and in what way?

SLEEP PATTERNS

On a scale from **1** (rarely) to **5** (very often) mark the conditions pertinent to you.

____Fall asleep fast
____Hard to fall asleep, but stay asleep
____Wake often
____Restless sleep
____Hard to wake up
____Sleep through the night
____Hard to fall and stay asleep
____Wake up to urinate
____Restful sleep
____Stay awake till 11:00 pm

Other_____

Which are your favourite hours to sleep?_____

Generally, how many hours of sleep do you need to feel rested?_____

Do you feel rested when you wake in the morning?_____

Dreams (circle those that apply): active, lucid, anxious, nightmares, probing, pleasant, interesting, scary, other_____

REVIEW OF BODY SYSTEMS

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE IN LAST 3 MONTHS.

SKIN, HAIR AND NAILS

Mark any of the conditions below that pertain to you. Use '**P**' for past problem and '**C**' for current.

____Acne
____Dandruff
____Eczema/psoriasis
____Impetigo
____Oily hair
____Rashes
____Skin tags
____brittle, cracking nails
____Boils
____Dry hair
____Hair loss
____Itchy
____Oily skin
____Scars
____Slow to heal
____lines, ridges and marks on nails
____Bruise easily
____Dry skin
____Hives
____Moles changes
____Pimples
____Sensitive to chemicals
____Texture changes

Any other problems with skin, hair or nails? _____

EYES, EARS, NOSE, MOUTH AND THROAT

Eyes

Have you previously had '**P**' or currently have '**C**'

____do you wear corrective lenses/glasses?
____blurred vision
____does the prescription for these change often?
____spots in front of eyes

Other_____

Date of last eye examination _____

Ears

Have you previously had '**P**' or currently have '**C**'

____Ear infections
____Overly sensitive
____ changes in hearing
____Earaches
____Tinnitus/Ringing
Other_____
____Hearing loss
____Wax build-up

Nose, Mouth & Throat

Please list '**P**' for previous or '**C**' for current conditions

____Cavities
____Excess saliva
____Oral herpes/ cold sores
____Sore gums
____Swollen tongue
____grinding teeth
____Constant dryness
____Lip sores
____Painful/tight/clicking jaw
____Sore throats
____mucous in throat
____sinus congestion
____Difficultly swallowing
____Mouth sores
____changes in sense of smell
____Swollen glands
____canker sores
Other_____

CARDIO VASCULAR HEALTH

Please check the below questions pertinent to your health:

____Black and blue easily ____Congenital deformities ____Fast heart beat (tachycardia)
____Heart irregularities ____Heart murmur ____fainting
Other_____

ENDOCRINE SYSTEM

Please check the below questions pertinent to your health:

____intolerance to heat or cold ____excessive thirst ____sudden energy drops
____easy weight gain ____hard to gain weight ____light-headedness/dizziness
____irritability/disoriented ____sweatiness
____symptoms when missed a meal (please list if so):

MUSCULOSKELETAL

Have you had an injury or surgery on bone, muscle, tendon, cartilage or related issue? If so, when and where?

RESPIRATORY

Please mark with a '**P**' for previously a problem, '**C**' for currently so, and '**?**' if unsure.

____Asthma ____Bronchitis ____Chest pain or when breathing
____Common cold ____Coughing ____Difficulty smelling
____Flu (influenza) ____Fluid in lungs ____Hay fever
____Laryngitis ____Pleuritis ____Respiratory inflammation
____Runny nose ____Shortness of breath ____Sneezing
____Stuffy nose ____Tight around lungs ____Trouble breathing in
____Trouble breathing out ____ Wheezing ____Tuberculosis
Other_____
Have you identified foods, environmental factors or situations that worsen your breathing? If so, what are they?

Mucous (check the symptoms which pertain to you) Yes____ No ____
What are the quality and/or color of the mucous:

____Clear ____Green ____Yellow
____Thick/sticky ____Thin/runny
____Worse in the morning, afternoon, evening, and/or night (circle)
Do you have much congestion? Which season is it worse and best? What helps it?

Cough (check the symptoms which pertain to you) Yes____ No ____

____Bloody ____Dry cough ____Hacking
____Itchy throat ____Painful ____Persistent
____Regularly ____Wet cough
____Worse at morning, afternoon, evening and/or night (circle)
Do you know of any things that trigger the cough?

URINARY

Please mark '**P**' for previous and '**C**' for current for any of the below conditions or '**?**':

____Bloating ____Blood in urine ____Burning urination
____Frequent urge to urinate ____Kidney/bladder stones ____Kidney pain
____Lower back pain ____Strong smelling urine ____Water retention
____pain when urinating ____inability to hold urine Other_____
Have you had urinary tract infections? How often? How did you treat them?

GASTRO-INTESTINAL

Digestion

Please use '**P**' for previously, '**C**' for currently or '**?**' for unsure.

____Belching	____Changes in bowel habits	____Crohn's disease
____Constipation	____Diarrhea	____Diverticulitis
____Eating disorders	____Flatulence/gas	____Food unappetizing
____Giardia	____Irritable bowel syndrome	____Large appetite
____Low appetite	____Nausea	____Pain after eating
____Parasites	____Ulcer	____Stomach aches
____Sudden weight change	____Ulcerative colitis	____Vomiting

Other_____

Bowel Movements (check the symptoms which pertain to you)

____black stools	____difficulty digesting fats	____mucous in stools
____blood in stools	____white or light grey stools	____oily film on stools or in toilet bowl
____floating stools	____sinking stools	Other_____

How many times a day do you have a bowel movement/defecate?_____
Do your feces tend toward loose (soft) or hard (formed)?_____
Are you ever constipated? If so, how often?_____
Do you ever have diarrhoea (very loose stools)? If so, how often?_____
Is your need to defecate urgent?_____
Does it ever hurt to defecate?_____

DIET

Please fill in the below chart using the following scale:
F –Frequently consume (daily or more)
O– Occasionally consume (a few times a week)
I – Irregularly consume, generally less than once a week
D – Do not consume this

____Wheat	____Baked goods	____Beef	____ Sweets
____ Refined sugar	____Bread	____Cheese	____Chicken
____Eat out	____Eggs	____Fast food	____Fermented foods
____Fish	____Fried foods	____Fruit	____Grains
____Herbal tea	____Juice	____Nut butters	____Nuts/seeds
____Organic foods	____Pork	____Potato chips	____Refined flour/white flour
____Seafood	____Seaweed	____Sodas/Pop	____Vegetables cooked
____Vegetables raw	____Milk and milk products	____Water	

Other _____

Special diets; current and/or previous_____
What are your favourite and least favourite foods?_____
How much do you drink everyday? What do you drink?_____

What did you have for snacks, breakfast, lunch and dinner yesterday?

NERVOUS SYSTEM AND STRESS

Please mark with '**P**' for previously and '**C**' currently to any conditions that are pertinent to you. Please also follow a scale of **1** (noticeable but not a big problem) to **5** (major problem).

____Anxiousness	____Bipolar	____Cannot stay asleep
____Depression	____Hard to concentrate	____Involuntary spasms
____Mania	____Memory loss	____Nervousness
____Pain – constant	____Panic attacks	____Seasonal affective disorder
____Sudden mood swings	____Trouble falling asleep	____Twitching
____Worsening coordination/balance	____low energy	____Seizures
____irritable	Other_____	

Are their any other concerns you wish to share?
Please use this space or another sheet to write anything else you feel may be important.

STATEMENT OF ACKNOWLEDGEMENT

The health care system in Ontario is under scrutiny. In order to clarify my position as a herbalist, I ask for your co-operation in signing this statement of acknowledgement.

1. That you understand that I am a herbalist not a medical doctor; that I use non-invasive natural methods of assessment and treatment of body dysfunction.
2. That you understand that the methods utilised in this office have a proven clinical foundation, yet may not be accepted practice by standard (allopathic) medicine.
3. That you understand that I reserve the right to determine which cases fall outside of my scope of practice, in which event an appropriate referral will be recommended.
4. That you are accepting or rejecting this care of your own free will.
5. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I provide are not in agreement.
6. That you understand that fees are payable at the time of the appointment by the patient or guardian. 24 hours notice is required for appointment cancellations; otherwise you will be responsible for the full fee. Any special financial arrangement may be made with me prior to the consultation.

I, _____ have read, understood and acknowledge the above statements.
(Print name)

Signature: _____ Date: _____
(Guardian if applicable)

Please sign and date prior to consultation.