purewellness group

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To help us serve your health needs, please take 20-30 minutes to complete the following questionnaire as accurately as possible. All of your answers will be held ***absolutely confidential***. If you have any questions, please ask. Thank you!

This intake is for children 0-12 years of age

GENERAL INFORMATION

Date:

Name: Health Card #:

Date of Birth: Gender: Blood Type

Address:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

Marital Status:

Emergency Contact: Relationship

Physician: Phone:

Chiropractor: Phone:

Naturopath: Phone:

Specialist(s): Phone:

Phone:

How did you hear about us?

ALLERGIES/SENSITIVITIES

COMPLAINTS/CONCERNS

Please state your reason for attending our clinic:

Did something trigger your change in health?

What aggravates it?

What improves it?

Have you been given a diagnosis?

Please list current and ongoing problems in order of severity:

Describe Problem(s)	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair

Dr. Allan Price ND #934 & Dr. Tara O'Brien ND #1725

Members in Good Standing with the Canadian Association of Naturopathic Doctors and the Ontario Association of Naturopathic Doctors
Pure Wellness Group is located at 1933 Regent St. Unit#10, Sudbury, ON P3E5R2

MEDICAL HISTORY

Please check the appropriate box and provide the date of onset
P = Past Condition **O = Ongoing Condition**

DISEASES/DIAGNOSES

P O GASTROINTESTINAL

- ◯ ◯ Irritable Bowel Syndrome
- ◯ ◯ Crohn's
- ◯ ◯ Ulcerative Colitis
- ◯ ◯ Gastric or Peptic Ulcer Disease
- ◯ ◯ GERD (reflux)
- ◯ ◯ Celiac Disease
- ◯ ◯ _____

P O CARDIOVASCULAR

- ◯ ◯ Heart Attack
- ◯ ◯ Other Heart Disease
- ◯ ◯ Stroke
- ◯ ◯ Elevated Cholesterol
- ◯ ◯ Arrhythmia (irregular heart rate)
- ◯ ◯ Hypertension (high blood pressure)
- ◯ ◯ Rheumatic Fever
- ◯ ◯ Mitral Valve Prolapse
- ◯ ◯ _____

P O MUSCULOSKELETAL/PAIN

- ◯ ◯ Osteoarthritis
- ◯ ◯ Fibromyalgia
- ◯ ◯ Chronic Pain
- ◯ ◯ _____

P O GENITAL & URINARY SYSTEMS

- ◯ ◯ Kidney Stones
- ◯ ◯ Urinary Tract Infections
- ◯ ◯ Yeast Infections
- ◯ ◯ _____

P O CANCER

- ◯ ◯ _____

P O INFLAMMATION/AUTOIMMUNE

- ◯ ◯ Chronic Fatigue Syndrome
- ◯ ◯ Autoimmune Disease
- ◯ ◯ Rheumatoid Arthritis
- ◯ ◯ Lupus SLE
- ◯ ◯ Immune Deficiency Disease
- ◯ ◯ Severe Infectious Disease
- ◯ ◯ Poor Immune Function (frequent infections)
- ◯ ◯ Food Allergies
- ◯ ◯ Environmental Allergies
- ◯ ◯ Multiple Chemical Sensitivities
- ◯ ◯ _____

P O METABOLIC/ENDOCRINE

- Type 1 Diabetes
- Type 2 Diabetes
- Hypoglycemia
- Metabolic Syndrome (insulin resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid)
- Hyperthyroidism (overactive thyroid)
- Endocrine Problems
- Polycystic Ovarian Syndrome (PCOS)
- Weight Gain
- Weight Loss
- Eating Disorder (specify)
-

P O RESPIRATORY DISEASES

- Asthma
- Chronic Sinusitis
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Sleep Apnea
-

P O SKIN DISEASES

- Eczema
- Psoriasis
- Acne
- Skin Cancer
-

P O NEUROLOGIC/MOOD

- Depression
- Anxiety
- Bipolar Disorder
- Schizophrenia
- Headaches
- Migraines
- ADD/ADHD
- Autism
- Mild Cognitive Impairment
- Memory Problems
- Parkinson's Disease
- Multiple Sclerosis
- ALS
- Seizures
-

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PREVENTATIVE TESTS

Check box if yes and provide date of last test

- ◯ Full Physical Exam
- ◯ Bone Density
- ◯ Colonoscopy
- ◯ Cardiac Stress Test
- ◯ EKG
- ◯ HemoccultTest (blood in stool)
- ◯ MRI
- ◯ CT Scan
- ◯ Upper Endoscopy
- ◯ Ultrasound

SURGERIES

Check box if yes and provide date of surgery

- ◯ Appendectomy
- ◯ Hysterectomy +/- Ovaries
- ◯ Gall Bladder
- ◯ Hernia
- ◯ Tonsillectomy
- ◯ Dental Surgery
- ◯ Joint Replacement
- ◯ Angioplasty or Stent
- ◯ Pacemaker
- ◯ None

HOSPITALIZATIONS/INJURIES

Date Reason/Event

COMMENTS

GYNECOLOGIC HISTORY (for women only)

Check circle and provide number of if applicable

MENSTRUAL HISTORY

Age at first period: Frequency: Length: Pain: ◯ Yes ◯ No Clotting: ◯ Yes ◯ No

Has your child ever skipped a cycle?: *If so, for how long?*

First day of last menstrual period: Days between menses:

Does your child use hormonal contraception?: ◯ Yes ◯ No *If so what type?:* *For how long?:*

Do you use contraception? ◯ Yes ◯ No *If so what type?:* ◯ Condom ◯ Diaphragm ◯ Partner Vasectomy ◯ IUD ◯ Tubal Ligation ◯ OTHER

WOMEN'S DISORDERS/HORMONAL IMBALANCES

◯ Fibrocystic Breasts ◯ Endometriosis ◯ Fibroids ◯ Infertility ◯ Painful Periods ◯ Heavy Periods

◯ PMS ◯ Spotting ◯ Vaginal Discharge ◯ Low Sex Drive

Last Self Breast Exam: Results: ◯ Normal ◯ Abnormal

Describe any changes to body/psyche prior to menses:

Symptoms

◯ Hot Flashes ◯ Mood Swings ◯ Concentration/Memory Problems ◯ Loss of Bladder Control

◯ Heavy Bleeding ◯ Joint Pain ◯ Headaches ◯ Weight Gain ◯ Palpitations

◯ Use of Hormone Replacement Therapy *If so, for how long?:*

GASTROINTESTINAL HISTORY

Foreign Travel?: ◯ Yes ◯ No *If so, where?*

Wilderness Camping? ◯ Yes ◯ No *If so, where?*

Have you ever had severe: ◯ Gastroenteritis ◯ Diarrhea

Does your child digest food well?: ◯ Yes ◯ No

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES:

Number of Pregnancies: Live Births: Miscarriages:

◯ **Term** ◯ **Premature**

MOTHER'S PREGNANCY: *Check box if yes and provide description if applicable*

- ◯ Difficulty getting pregnant
- ◯ Infertility drug used. Specify
- ◯ In vitro fertilization
- ◯ Alcohol consumed
- ◯ Coffee consumed
- ◯ Smoked tobacco
- ◯ Took Progesterone
- ◯ Took Prenatal Vitamins
- ◯ Took antibiotics
- ◯ Excessive nausea and vomiting
- ◯ Infections
- ◯ Had amalgams removed or implanted
- ◯ Vaginal bleeding
- ◯ Had birth complications
- ◯ Group B Strep Infection
- ◯ Had a C-section
- ◯ Labour induction
- ◯ Used anaesthesia
- ◯ Used oxygen during labour
- ◯ Had an X-ray
- ◯ Had RhoGAM shot, if so, how many
- ◯ Gestational Diabetes
- ◯ Elevated blood pressure
- ◯ Had chemical exposure
- ◯ Father had chemical exposure
- ◯ Moved to a newly built home
- ◯ House painted indoors or outdoors
- ◯ House exterminated for insects

PREGNANCY

Total weight gain during pregnancy: *lbs.* Total weight loss during pregnancy: *lbs.*

Please describe diet during pregnancy:

Please describe labour:

Mother - Personal Age at child's birth: Ethnicity: Blood type:

Father - Personal Age at child's birth: Ethnicity: Blood type:

PERINATAL

Pregnancy duration: *Weeks*

Hospital/Birthing Centre?: ◯ Yes ◯ No

Needed Newborn Special care?: ◯ Yes ◯ No

Easily consoled during first month?: ◯ Yes ◯ No

Antibiotics first month?: ◯ Yes ◯ No

Experienced complications during first month?: ◯ Yes ◯ No

BIRTH WEIGHT AND APGAR

Weight at birth: *lbs./oz*

Apgar Score at 1 minute:

Apgar Score at 5 minutes:

EARLY CHILDHOOD ILLNESS

Number of earaches in the first two years:

Number of other infections in the first two years:

Number of times your child has antibiotics in the first two years of life:

First illness at: *months*

DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?: *months/years*

Is this impression shared among parents and others caring for your child?: ◯ Yes ◯ No

DEVELOPMENTAL HISTORY

please indicate the approximate age in months for the following milestones (ex: walking 14 months)

Sitting up	*months*	◯ Never	Dry at night	*months*	◯ Never
Crawl	*months*	◯ Never	First words	*months*	◯ Never
Pulled to stand	*months*	◯ Never	Spoke clearly	*months*	◯ Never
Potty trained	*months*	◯ Never	Lost language	*months*	◯ Never
Walked alone	*months*	◯ Never	Lost eye contact	*months*	◯ Never

DENTAL HISTORY

DENTAL SURGERY

◯ **Silver/Mercury Fillings** *If so, how many?:* _____ ◯ **Gold Fillings** ◯ **Root Canals** ◯ **Implants**

◯ **Tooth Pain** ◯ **Bleeding Gums** ◯ **Gingivitis** ◯ **Problems Chewing**

Do you floss regularly?: ◯ **Yes** ◯ **No** *How many days per week?:* _____

MEDICATIONS

CURRENT MEDICATIONS *(or attach pharmacist print out)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON TO USE

IMMUNIZATION HISTORY *(or attach Immunization Record or fill out to the best of your memory*

IMMUNIZATION	DATE RECEIVED	REACTIONS (IF ANY)
DPT		
Tetanus		
MMR		
Haemophilus influenza B		
Flu		
Polio		
Hepatitis A & B		

PAST MEDICATIONS *(last 10 years, fill in to the best of your ability)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON TO USE

NUTRITIONAL SUPPLEMENTS *(vitamins, minerals, herbs, homeopathy)*

SUPPLEMENT OR BRAND	DOSE	FREQUENCY	START DATE	REASON TO USE

Have medications or supplements ever caused you unusual side effects or problems?: ◯ Yes ◯ No

If so, please describe: _____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, or Aspirin?: ◯ Yes ◯ No

Has your child had prolonged or regular use of Tylenol?: ◯ Yes ◯ No

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ◯ Yes ◯ No

Frequent antibiotic use (>3 times/year)? ◯ Yes ◯ No Long-term antibiotic use?: ◯ Yes ◯ No

Use of steroids (prednisone, nasal allergy inhalers) in the past?: ◯ Yes ◯ No

Use of oral contraceptives?: ◯ Yes ◯ No

FAMILY HISTORY

Check family members that apply

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/Uncles	Details
Age *(if alive)*											
Age at death *(if deceased)*											
Cancer *(breast, colon, leukemia, etc.)*											
Heart Disease											
Obesity											
Diabetes											
Stroke											
Arthritis											
Inflammatory Bowel Disease											
Autoimmune Disease *(Lupus, MS, etc.)*											
Gastrointestinal Issues *(IBS, Celiac, Crohn's, etc.)*											
Allergy/Skin Issues *(Eczema, Asthma, Environmental Sensitivities, etc.)*											
Parkinson's											
ALS or Motor Neuron Diseases											
Genetic Disorders											
Mental Health Issues *(substance abuse, psychiatric disorders, depression, schizophrenia, ADHD, Autism, Bipolar, Dementia, etc.)*											

SOCIAL HISTORY

NUTRITION HISTORY *(Describe your typical daily diet)*

BREAKFAST	DINNER

LUNCH	SNACKS

Have you ever had a nutritional consultation?: ◯ **Yes** ◯ **No**

Has your child made any changes to your eating habits because of their health?: ◯ **Yes** ◯ **No** *Describe:* _____

Does your child currently follow a special diet or nutritional program?: ◯ **Yes** ◯ **No** *Describe:* _____

Does your child have cravings for a specific item(s)?: ◯ **Yes** ◯ **No** *to what?* _____

Height: Weight: Usual Weight Range (+/- 5lbs): _____

Weight Fluctuations (>10lbs): ◯ **Yes** ◯ **No**

How often do you weigh yourself?: ◯ **Daily** ◯ **Weekly** ◯ **Monthly** ◯ **Rarely** ◯ **Never**

Do you grocery shop? ◯ **Yes** ◯ **No** *if no, who does the cooking?* _____

Do you read food labels? ◯ **Yes** ◯ **No** *if yes, what are you looking for?* _____

Do you cook?: ◯ **Yes** ◯ **No** *if no, who does the shopping?* _____

Check all the factors that apply to your current lifestyle and eating habits:

◯ **Fast eater** ◯ **Erratic eating pattern** ◯ **Eat too much** ◯ **Late night eating** ◯ **Dislike healthy food**

◯ **Time constraints** ◯ **Eat more than 50% of meals away from home** ◯ **Travel frequently**

◯ **Non-availability of healthy food** ◯ **Do not plan meals or menus** ◯ **Reliance on convenience items**

◯ **Poor snack choices** ◯ **Significant other or family members do not like healthy foods**

◯ **Significant other or family members have special dietary needs or preferences** ◯ **Eat in the middle of the night**

◯ **Struggle with eating issues** ◯ **Emotional eater** ***(eat when sad, lonely depress or bored)*** ◯ **Eat too much under stress**

◯ **Eat too little under stress** ◯ **Don't care to cook** ◯ **Confused about nutrition advice**

◯ **Love to eat** ◯ **Eat because I have to** ◯ **Have a negative relationship with food**

BREASTFEEDING HISTORY

Breastfed?: ◯ Yes ◯ No *if so, for how long?* _____

Problems with latch?: ◯ Yes ◯ No Exclusively breastfed for _____ *months*

BOTTLE FED HISTORY

Bottle fed?: ◯ Yes ◯ No Type of formula?: ◯ Soy ◯ Cow Milk ◯ Low Allergy ◯ Goat

Introduction of cow's milk at _____ *months* Introduction of solid food at _____ *months*

Introduction of wheat or grain at _____ *months* Choke and/or vomit on milk ◯ Yes ◯ No

Refused to chew solids?: ◯ Yes ◯ No

List of mother's known food allergies or sensitivities: _____

Please describe any other eating concerns that you have regarding your child: _____

SMOKING

Currently Smoking? ◯ Yes ◯ No *if so, for how many years* _____ *how many packs per day* _____

# of Attempts to Quit: _____ Previous Smoking?: *for how many years* _____ *how many packs per day* _____

Second Hand Smoke Exposure?: _____

OTHER SUBSTANCES

Caffeine?: ◯ Yes ◯ No *Coffee cups/day:* ◯ 1 ◯ 2-4 ◯ >4 *BlackTea cups/day:* ◯ 1 ◯ 2-4 ◯ >4

Caffeinated Soda or Diet Soda?: ◯ Yes ◯ No *12 ounce can or bottle/day:* ◯ 1 ◯ 2-4 ◯ >4

Are you currently using any recreational drugs?: ◯ Yes ◯ No *if so, what type?* _____

EXERCISE

Current Exercise Program: (Describe your weekly exercise regime, including sports, leisure activities, stretching, etc.)

Rate your level of motivation for including exercise in your life: ◯ Low ◯ Medium ◯ High

Do you have any problems that limit activity?: ◯ Yes ◯ No *if so, describe?* _____

Do you feel unusually fatigued after exercise?: ◯ Yes ◯ No Do you usually sweat when exercising?: ◯ Yes ◯ No

PSYCHOSOCIAL

Is your child significantly less vital than they were a year ago?: ◯ Yes ◯ No Is your child happy?: ◯ Yes ◯ No

Do you believe stress is presently reducing your quality of life?: ◯ Yes ◯ No

Do you like the work you do?: ◯ Yes ◯ No Have you ever experienced major losses in your life?: ◯ Yes ◯ No

Has your child ever experienced major losses in their life? ◯ Yes ◯ No

STRESS/COPING

Has your child ever had counseling?: ◯ Yes ◯ No

Is your child currently in therapy?: ◯ Yes ◯ No *if so, describe?* _____

Do you have an excessive amount of stress in your life?: ◯ Yes ◯ No

Daily Stressors: *(rate on a scale of 1-10, 10 being the worst)*

Work _____ **Family** _____ **Social** _____ **Finances** _____ **Health** _____ **Other** _____

Has your child ever been the victim of a crime, experienced significant trauma, or been physically, sexually or emotionally abused?: ◯ Yes ◯ No

SLEEP/REST

Average number of hours your child sleeps per night: ◯ >10 ◯ 8-10 ◯ 6-8 ◯ <6

Does your child have trouble falling asleep?: ◯ Yes ◯ No

Does your child seem rested upon awakening? ◯ Yes ◯ No

Does your child have problems with insomnia?: ◯ Yes ◯ No Do you snore?: ◯ Yes ◯ No

HOME LIFE

ROLES/RELATIONSHIPS

Who is living in the household?: *Number of people:* _____ *Ages* _____

Resources for emotional support?: *check all that apply*

◯ Family ◯ Friends ◯ Religious/Spiritual ◯ Pet(s) ◯ Other _____

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions, sensitivities, or allergies?: ◯ Yes ◯ No

If yes, describe symptoms: _____

List all known: _____

When you drink caffeine, do you feel: ◯ Irritable or Wired ◯ Aches & Pains

Which of these significantly affect you?: *check all that apply*

◯ Cigarette Smoke ◯ Perfumes/Colognes ◯ Auto Exhaust Fumes ◯ Other _____

In your work or home environment, are you exposed to: ◯ Chemicals ◯ Electromagnetic Radiation ◯ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

◯ Herbicides ◯ Insecticides *(frequent visits by exterminator)* ◯ Pesticides ◯ Organic Solvents

◯ Heavy Metals ◯ Other _____

Chemical Name, Date & Length of Exposure: _____

Do you dry clean your clothes frequently?: ◯ Yes ◯ No Do you have any pets or farm animals?: ◯ Yes ◯ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure?: ◯ Yes ◯ No

SYMPTOM REVIEW

Please check all current symptoms occurring or present

GENERAL

◯ Poor appetite ◯ Poor sleep ◯ Fatigue ◯ Fevers ◯ Chills ◯ Night sweats ◯ Sweat easily

◯ Tremors ◯ Cravings ◯ Localized weakness ◯ Poor Balance ◯ Change in appetite

◯ Bleed or bruise easily ◯ Peculiar tastes or smells ◯ Strong thirst *(cold or hot drinks)*

◯ Chronic infections ◯ Sudden energy drop *what time of day?:* _____

SKIN AND HAIR

◯ Rashes ◯ Ulcerations ◯ Hives ◯ Itching ◯ Pimples ◯ Dandruff ◯ Loss of hair

◯ Recent moles ◯ Change in hair or skin texture

◯ Any other hair or skin problems? *describe:* _____

HEAD, EYES, EARS, NOSE AND THROAT

◯ Dizziness ◯ Loss of balance ◯ Areas of numbness ◯ Lack of coordination ◯ Poor memory

◯ Concussion ◯ Quick temper/irritable ◯ Easily susceptible to stress ◯ Panic attacks

◯ Have you ever received treatment for emotional problems?

◯ Have you ever considered or attempted suicide?

◯ Any other neurological or psychological problems? *describe:* _____

CARDIOVASCULAR

◯ Low blood pressure ◯ Chest pain ◯ Irregular heartbeat ◯ Dizziness ◯ Fainting

◯ Cold hands or feet ◯ Swelling of hands ◯ Swelling of feet ◯ Phlebitis ◯ Blood clots

◯ Difficulty breathing ◯ Any other heart or blood vessel problems? *describe:* _____

RESPIRATORY

◯ Cough ◯ Coughing Blood ◯ Pain with a deep breath ◯ Difficulty breathing when lying down

◯ Production of phlegm *colour?* _____ ◯ Any other lung problems? *describe:* _____

GENITO-URINARY

◯ Pain on urination ◯ Frequent urination ◯ Blood in urine ◯ Urgency to urinate

◯ Unable to hold urine ◯ Decrease in flow ◯ Sores on genitals

◯ Wakes to urinate? *how often?:* _____

◯ Any particular colour to urine? *describe:* _____

◯ Any other problems with your genitals or urinary system? *describe:* _____

NEUROPSYCHOLOGICAL

◯ Dizziness ◯ Loss of balance ◯ Areas of numbness ◯ Lack of coordination ◯ Poor memory

◯ Concussion ◯ Quick temper/irritable ◯ Easily susceptible to stress ◯ Panic attacks

◯ Ever been treated for emotional problems? ◯ Ever considered or attempted suicide?

◯ Any other neurological or psychological problems? *describe:* _____

MUSCULO-SKELETAL

◯ Joint pain ◯ Stiffness ◯ Lack of flexibility ◯ Radiating pain ◯ Headaches/Migraines

◯ Low back pain ◯ Foot pain ◯ Neck pain ◯ Trauma *(ie. MVA, slip, fall)* ◯ Joint pain

◯ Jaw clicks ◯ Any other head or neck problems? *describe:* _____

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Take several nutritional supplements each day _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Keep a record of everything you eat each day _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Modify your lifestyle *(e.g., work demands, sleep habits)* _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Practice a relaxation technique _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Engage in regular exercise _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1
Have periodic lab tests to assess your progress _____	◯ 5	◯ 4	◯ 3	◯ 2	◯ 1

Comments

_____

_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

◯ 5 ◯ 4 ◯ 3 ◯ 2 ◯ 1

Comments

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support and contact (e.g. telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

◯ 5 ◯ 4 ◯ 3 ◯ 2 ◯ 1

Comments