purewellness group

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purewellnessgroup.ca

To help us serve your health needs, please take 10-15 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: YYYY / MM / DD

Name: FIRST MIDDLE LAST Health Card #: 0000 - 000 - 000 - XX

Date of Birth: YYYY / MM / DD Gender: Blood Type: XX -

Address: STREET APT. #

CITY PROVINCE POSTAL CODE

Home Phone: (000) 000-0000 Work Phone: (000) 000-0000

Cell Phone: (000) 000-0000 E-mail Address: YOU@SITE.COM

Contact: NAME RELATIONSHIP TO CHILD

PHONE NUMBER

Physician: NAME PHONE NUMBER

Chiropractor: NAME PHONE NUMBER

Naturopath: NAME PHONE NUMBER

Specialist(s): NAME PHONE NUMBER

NAME PHONE NUMBER

How did you hear about our clinic?

◯ Tradeshow ◯ Drive-by/Walk-in ◯ Medical Doctor/Nurse Practitioner ◯ TruBalance/TruTina

◯ Internet ◯ Facebook ◯ Instagram ◯ Twitter ◯ Google ◯ Midwife ◯ Website

◯ Another patient or professional: _____

ALLERGIES/SENSITIVITIES

MEDICATION/SUPPLEMENT/FOOD REACTION

COMPLAINTS/CONCERNS

Please state your reason for attending our clinic:

Did something trigger your change in your child's health?

What aggravates it?

What improves it?

Has your child 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
EXAMPLE: POST NASAL DRIP		X			X		

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

Members in Good Standing with the Canadian Association of Naturopathic Doctors and the Ontario Association of Naturopathic Doctors
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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
- Inflammatory Bowel Syndrome
- Crohn's
- Ulcerative Colitis
- Gastric or Peptic Ulcer Disease
- GERD *(reflux)*
- Celiac Disease
- OTHER

P O GENITAL AND URINARY SYSTEMS

- Kidney Stones
- Urinary Tract Infections
- Yeast Infections
- OTHER

P O CANCER

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 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 MUSCULOSKELETAL/PAIN

- Osteoarthritis
- Fibromyalgia
- Chronic Pain
- OTHER

SKIN DISEASES

P O

- Eczema
- Psoriasis
- Acne
- Skin Cancer
- OTHER

RESPIRATORY DISEASES

P O

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

NEUROLOGIC/MOOD

P O

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

PREVENTATIVE TESTS

Check box if yes and provide date of last test

- Full Physical Exam YYYY / MM / DD
- Psychological Evaluations YYYY / MM / DD
- Speech and Language Evaluations YYYY / MM / DD
- Genetic Evaluations YYYY / MM / DD
- Neurological Evaluation YYYY / MM / DD
- Gastroenterology Evaluation YYYY / MM / DD
- Celiac/Gluten YYYY / MM / DD
- Allergy Evaluation YYYY / MM / DD
- Auditory Evaluation YYYY / MM / DD
- Vision Evaluation YYYY / MM / DD
- Sensory Integration Therapy YYYY / MM / DD
- MIR YYYY / MM / DD
- CT Scan YYYY / MM / DD
- Upper Endoscopy YYYY / MM / DD
- Ultrasound YYYY / MM / DD

SURGERIES

Check box if yes and provide date of last test

- Appendectomy YYYY / MM / DD
- Gall Bladder YYYY / MM / DD
- Hernia YYYY / MM / DD
- Tonsillectomy YYYY / MM / DD
- Dental Surgery YYYY / MM / DD
- Heart Surgery YYYY / MM / DD
- Circumcision YYYY / MM / DD
- Tubes in Ears YYYY / MM / DD
- OTHER YYYY / MM / DD
- None

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HOSPITALIZATIONS/INJURIES

Date	Reason/Event
YYYY / MM / DD	
YYYY / MM / DD	

COMMENTS

GYNECOLOGIC HISTORY (for women only)

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?:*

Does your child use contraception?: ◯ Yes ◯ No If so, what type?: ◯ Condom ◯ Diaphragm ◯ IUD ◯ OTHER

WOMEN'S DISORDERS/HORMONAL IMBALANCES

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

◯ PMS ◯ Spotting ◯ Vaginal Discharge

Last Self Breast Exam: YYYY / MM / DD Last PAP Test: YYYY / MM / DD 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 Pains ◯ 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 Strept Infection
- ◯ Had a C-section
- ◯ Labour induction
- ◯ Used anesthesia
- ◯ 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: _____

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 antibiotic at: _____ *months* 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 with Chewing**

Does your child floss regularly?: ◯ **Yes** ◯ **No** *How many days per week?:* _____

MEDICATIONS

CURRENT MEDICATIONS *(or attach pharmacist print out)*

MEDICATION	DOSE	FREQUENCY	START DATE	REASON FOR 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 FOR USE

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

SUPPLEMENT OR BRAND	DOSE	FREQUENCY	START DATE	REASON FOR USE

Have medications or supplements ever caused your child 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, Biopolar, Dementia, etc.)*											

SOCIAL HISTORY

NUTRITION HISTORY *(Describe your child's typical daily diet)*

Breakfast _____ **Dinner** _____

Lunch _____ **Snacks** _____

Has your child ever had a nutrition 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): _____

Desired Weight Range (+/- 5lbs): Highest Weight: Lowest Weight: _____

Weight Fluctuations (>10lbs): ◯ **Yes** ◯ **No** Body Fat %: _____

Check all the factors that apply to your child's 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 they have to** ◯ **Have a negative relationship with food**

BREASTFED 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 foods at _____ *months*

Introduction of wheat or grain at _____ *months* Choke/Gas/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 *Black Tea 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 weekly exercise regime, including sports, leisure activities, stretching, etc.)*

_____

_____

_____

_____

Does your child feel unusually fatigued after exercise?: ◯ Yes ◯ No

Does your child 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 child's quality of 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:* _____

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 Does your child 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 _____

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

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Does your child have known adverse food reactions, sensitivities, or allergies?: ◯ Yes ◯ No

If yes, describe symptoms: _____

List all known: _____

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

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

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 have any pets or farm animals?: ◯ 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 ◯ Concussions ◯ Migraines ◯ Glasses ◯ Eye strain ◯ Eye pain

◯ Poor vision ◯ Night blindness ◯ Color blindness ◯ Cataracts ◯ Blurry vision ◯ Earaches

◯ Ringing in ears ◯ Poor hearing ◯ Ear infections ◯ Sinus problems ◯ Nosebleeds

◯ Spots in front of eyes ◯ Grinding teeth ◯ Facial pain ◯ Sores on lips or tongue

◯ Canker sores ◯ Recurrent sore throats ◯ Tonsillitis ◯ Chronic swollen glands

◯ Teeth/gum problems *# of Mercury(silver amalgams):* _____

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:* _____

GASTROINTESTINAL

◯ Nausea ◯ Vomiting ◯ Constipation ◯ Diarrhea ◯ Chronic laxative use ◯ Indigestion

◯ Belching ◯ Gas ◯ Bad breath ◯ Black stools ◯ Blood in stools ◯ Rectal pain

◯ Abdominal pain or cramps

◯ Any other problems with your stomach or intestines? *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