Patient Information

Date: ______________________________ Alberta Health Care #: ______________________________

Name: ______________________________________ Phone: _________________________ (H/W/C – circle)

Address: ____

Birth Date: _____________________ Age: _____ Country of Birth: ______________________ Gender: M F

Mothers Name: ____

Fathers Name: ____

Is there a custody arrangement we should be aware of: ____

Emergency Contact: __________________________________ Phone: _________________________________

Current Medical Doctor: ______________________________ Phone: _________________________________

Please list any other practitioners you currently seeing (e.g. Naturopaths, massage therapists, chiropractors, specialists, other):

Practitioner: ____ Phone: _________________________________

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Practitioner: ____ Phone: _________________________________

Practitioner: ____ Phone: _________________________________

Date of last physical exam: _______________________________

How did you find out about the clinic: ____

Do you have extended Medical Coverage: Y N Insurer: ____

If yes, what services are covered: ____

Chief Health Concerns

What are your health concerns, in order of importance to you:

1. ______________________________

2. ______________________________

3. ______________________________

List any other concerns you may want to discuss:

____

____

What are your short-term goals (within the next 6 – 12 months)?

____

____

What are your long-term goals (2 – 5 years)?

____

____

Medical History

How would you describe your child's general state of health?

Excellent Good Fair Poor

Please list all your child's past & present injuries, surgeries and/or hospitalizations? Include approximate date(s) or age.

____

____

____

Please list all your child's allergies (medications, environmental, foods, other)?

____

____

Has your child ever had a reaction to anesthetics? Y N (local or general)

List ALL your child's current medications (prescription, over-the-counter, vitamins, herbs, etc), with dose and frequency that you take them:

Has your child ever been treated with antibiotics, and if so approximately how many times?

Does your child frequently ingest any of the following?

			Details: What & How often?
Laxatives	Y	N	
Antacids	Y	N	
Aspirin/Tylenol/Advil	Y	N	
Caffeine	Y	N	
Dairy	Y	N	
Sugar/Sweets (including fruit juice)	Y	N	

Is your child up to date on recommended immunizations? Yes No

Is there any chemicals, fumes, toxins, second hand smoke that your child may be exposed to? Please list:

Diet

Please list all known food allergies or intolerances? Does your child avoid these foods?

Do you avoid any other foods for other reasons (e.g. vegetarian/vegan, etc)?

Please describe your child's typical diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages (total amounts): ______________________________________

Health History (present & past)

Indicate if your child has or has had any of the following:

- ☐ Allergies
- ☐ Asthma
- ☐ Headaches/Migraines
- ☐ Sinus Problems
- ☐ Gallstones
- ☐ Appendicitis
- ☐ Tonsillitis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Conditions
- ☐ Diabetes
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Herpes (face or genital)
- ☐ Warts
- ☐ Parasites
- ☐ Epilepsy
- ☐ Mental Illness/Depression/Anxiety
- ☐ Abuse
- ☐ Ear Infections
- ☐ Digestive Problems
- ☐ Colic
- ☐ Croup
- ☐ Upper Respiratory Infections
- ☐ Bed Wetting
- ☐ Recurrent Fevers
- ☐ Strep Throat
- ☐ Night Terrors/Nightmares
- ☐ Constipation
- ☐ Diarrhea
- ☐ ADD/ADHD
- ☐ Coughing/Wheezing
- ☐ Mononucleosis
- ☐ Influenza
- ☐ Pneumonia
- ☐ Cystitis/UTI's
- ☐ Frequent Colds/Flus

Health History (present & past)

Indicate if a close relative (parent, sibling, grandparent) has any of the following:

- ☐ Allergies
- ☐ Asthma
- ☐ Headaches/Migraines
- ☐ Sinusitis
- ☐ Kidney conditions
- ☐ Arthritis (any)
- ☐ Heart condition
- ☐ Blood disorders
- ☐ Cancer: Type:_________________________
- ☐ Thyroid condition
- ☐ Skin Conditions
- ☐ Diabetes
- ☐ Warts
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Obesity
- ☐ Mental Illness/Depression/Anxiety

Please list all other notable past & present medical conditions?

____

____

Does your child exercise regularly? (min. 60 mins/day) Y N

What type of exercise, how much, how often?

____

____

What are your child's hobbies and interests?

____

How would you describe the emotional climate of your home? Are there any family dynamics that may be impacting your child?

____

____

How does your child sleep? How many hours per night?

____

____

Dose you child co-sleep? Yes No

Pre- and Postnatal:

Did you have an uneventful pregnancy? Any complications?

____
____
____
____

Medications taken during pregnancy (if any)?

____
____

How many weeks did you carry your child? ____

How was your labour and delivery? Was it a positive event for you?

____
____
____

Birth length/weight? ____

Did your midwife or OB have any concerns at birth?

____
____

Were you or your child hospitalized after birth?

____
____

Did you have post-partum depression? ____

Did you breast feed? If yes, how many months? ____

When did the introduction of the following foods occur?

Solids: ____

Cow's Milk: ____

Wheat: ____

Eggs: ____

Peanuts: ____

List any developmental concerns you may have (mental or physical):

____
____
____
____

Does your child currently attend daycare/school? ______________________________

How would you describe your child socially?

____
____
____
____

What does your family do together for fun?

____
____
____
____

Is there anything that you feel that is important that hasn't been covered?

____
____
____
____

CONSENT TO TREATMENT

1. I understand that Lacey Gerbrandt, ND is a Naturopathic Doctor, and will primarily use natural, minimally-invasive methods of assessment and treatment.

2. I understand that any advice given to my child as a patient from Lacey Gerbrandt, ND, is not mutually exclusive from any treatment or advice my child may now, or in the future, be receiving from another health care provider.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Canada.

4. I understand that the Naturopathic Doctor reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.

5. I understand that I am accepting or rejecting this care for my child by my own free will.

6. I understand that no employee at Vita Sana Naturopathic Wellness Clinic including Lacey Gerbrandt, ND, is suggesting that I refrain from seeking the advice of another health care provider for my child.

7. I understand that the services offered here are not typically covered by Alberta Health, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

8. I understand that 48-hour notice is required for appointment cancellation. Cancellation fees may apply.

9. By signing this consent form I am indicating that I am legally permitted to make care decisions on behalf of the minor named.

I ____ am the parent/legal guardian to ___________________________, and I have read, understood and agreed to the above statements.

Signature____ Date_____________________________