DOWNTOWN BRAMPTON WELLNESS CENTRE

118 QUEEN STREET WEST, SUITE 205, BRAMPTON, ON L6X 1A5
905-451-3963 • downtownbramptonwellness@bellnet.ca • bramptonwellness.ca

PLEASE NOTE THAT THESE FORMS MUST BE SIGNED AND FILLED OUT PRIOR TO YOUR CHILD'S 1ST APPOINTMENT

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors 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 will take a thorough case history, and may do a screening physical examination, including taking blood and urine samples.
It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that your child is suffering from, if he/she is on any medications or over the counter drugs.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles.

I understand that a record will be kept of the health services provided to my child. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my child's case with other healthcare providers. I understand that I may look at my child's medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my child's medical record may be analyzed for research purposes and that his/hers identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the Naturopathic care of my child.
I intend this consent form to cover the entire course of treatment for my child's present condition. I understand that I am free to withdraw my consent and to discontinue my child's participation at any time.

Patient Name: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Signature of Parent/Guardian: _____ Date: _____

Naturopathic Doctor: _____

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Child's Name:_____Date: _____

Address:_____ City: _____

Postal Code: _____ Family e-mail: _____

Date of birth _____ (M/D/Y) Age: _____ Sex: M / F

How did you hear about our office? _____

Parent(s)/Guardian(s) Name(s):

_____

_____

Phone - Mother _____ Phone - Father _____

Parents' Marital Status: _____No. of Siblings: _____

Family Physician: _____ Phone: _____

What are your child's **main health concerns**:

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY

Height _____ Weight_____

Hours of sleep per night? ___ Bedtime? _____

Known allergies? Y / N To what?

_____

_____

Vaccinations:

Polio ___ Diptheria ___ Pertussis ___ Tetanus ___ Measles ___ Mumps ___ Rubella ___ Chickenpox ___ Smallpox ___ Other _____

Childhood Diseases: (Y = Yes, P = Past, N = No)

Frequent colds	**Y**	**P**	**N**	Measles	**Y**	**P**	**N**
German Measles	**Y**	**P**	**N**	Chicken Pox	**Y**	**P**	**N**
Whooping Cough	**Y**	**P**	**N**	Frequent Rashes	**Y**	**P**	**N**
Injuries/burns	**Y**	**P**	**N**	Major Accidents	**Y**	**P**	**N**

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Medical History cont'd

How would you describe your child's general health? (circle)

Excellent Good Fair Poor

Birth History:

Weight at birth: _____ Rh incompatability? Y / N

Delivery (check) Normal ___ Premature ___ Caesarian ___
Forceps Aided ___ At Home ___ In Hospital ___ Difficult ___
Drug Aided ___ What Drugs? _____
Hours of Labor _____
Other comments regarding pregnancy:

_____
_____
_____

Feeding:

Breast? Y / N How many months? _____
Bottle? Y / N Type of Milk? _____
Solid foods started at _____ months
What food was first introduced? _____
Adverse reaction to foods?

_____
_____

Current Medications & how long taken:

_____
_____
_____

Current vitamins and supplements:

_____
_____
_____

Other treatments or health care?(e.g. physio, massage, chiropractic…)

_____
_____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations; along with approximate dates

_____
_____
_____

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Medical History cont'd

How many times has your child been treated with antibiotics? _____

Dietary restrictions? (religious, vegetarian/vegan, etc.)?

_____
_____
_____

Typical Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Lifestyle/Environment

Hobbies

_____
_____

Sports/Physical Activities

_____
_____

Exposure to significant tobacco smoke? Y / N
Frequently exposed to animals? Y / N
How is your family's home heated? _____

How would you describe the emotional climate of your home?

_____
_____
_____

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Family History

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

	Who?		Who?
Allergies		Depression	
Asthma		Other Mental Illness	
Heart Disease		Drug Abuse/Alcoholism	
High Blood Pressure		Kidney Disease	
Cancer		Other	
Diabetes		Other	

☐ I don't know our family medical history

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____
_____
_____

IF YOUR CHILD IS BETWEEN THE AGES OF 6 & 12, PLEASE HAVE THEM COMPLETE THE FOLLOWING QUESTIONS:

Please check if you have any of the following conditions:

Nervousness ___	Unhappiness ___	Hyperactivity ___
Sleep long hours ___	Laziness ___	Irritability ___
Discontentment ___	Slow learning ___	Accident prone ___

Do you: (Please answer Yes or No)
Have many fears? ___ Lack confidence? ___
Prefer to be alone? ___ Prefer to be with friends? ___
Prefer to be with family? ___ Get angry easily? ___
Have sleeping problems? ___ Bite Nails? ___
Grind teeth? ___ Wet the bed? ___
Have difficulty concentrating on schoolwork? ___ When reading? ___

Are your eyes sensitive to light? _____
How often do you miss school because of illness?
_____
Do you get along with your family? _____
If you could change something in your life what would it be?
_____
What do you worry about? _____
What are your main health concerns?
1. _____
2. _____
3. _____
4. _____