



**QUESTIONNAIRE**  
**OKOTOKS NATURAL HEALTH CENTRE**  
 29C ELIZABETH STREET  
 Ph:(403)995-9999 Fax:(403)995-9990



**“TAKING THE TIME TO LISTEN & WORKING TOGETHER MAKES A DIFFERENCE!”**

**PLEASE MAKE SURE YOU HAVE ALL 30 PAGES OF THIS FORM**

**OUR MISSION**

**TO HELP IMPROVE THE ROLE IN THE RECOVERY OF CHILDREN AFFECTED BY AUTISM SPECTRUM DISORDERS, IN COMBINING THE “DEFEAT AUTISM NOW” APPROACH WITH HOLISTIC HEALTH. THIS INCLUDES A VARIETY OF INTERVENTIONS, CUSTOMIZED ON AN INDIVIDUAL BASIS, WHICH HAVE BEEN SHOWN TO PRODUCE DRAMATIC RESULTS IN SOME PATIENTS, THE FOCUS BEING ON THE WHOLE PERSON TO RESTORE OPTIMAL HEALTH.**

**Holistic Health** is defined as a system of health care which emphasizes on personal responsibility, and care, a cooperative relationship among all those involved, leading toward optimal harmony of body, mind, emotions and spirit.

The following questionnaire, although somewhat long and detailed, is an invaluable source of information about you as a unique person. It will allow us to know the Total You, not just you as a collection of symptoms of an illness.

**PLEASE NOTE:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

Would you be willing to sign a release to obtain medical records from your previous doctor(s) and hospital(s), if this information would be helpful for your treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, then sign below.

**AUTHORIZATION FOR MEDICAL INFORMATION**

This will authorize (Dr.) \_\_\_\_\_ of

(Clinic) \_\_\_\_\_

to provide Dr. KURT HARTMANN ND, or his/her representative, with any and all information in regards to any form of treatment applied to me, including blood tests, X - rays, findings and diagnoses. A copy of this authorization is valid as well as an original.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

| <b>Personal Information</b>   |                  |
|-------------------------------|------------------|
| Date of Initial Consultation: |                  |
| <b>Child's</b> First Name:    |                  |
| Last Name:                    |                  |
| Middle Initial:               |                  |
| D.O.B.(m/d/y)                 |                  |
| Sex:(m/f)                     |                  |
| Address: Street:              |                  |
| City:                         |                  |
| State/Province:               |                  |
| Postal Code:                  |                  |
| Phone Number:                 |                  |
| Cell Phone Number:            |                  |
| <b>Weight: Now:</b>           |                  |
| <b>One year ago:</b>          |                  |
| <b>Maximum weight:</b>        |                  |
| <b>When:</b>                  |                  |
| <b>Height cm/ft</b>           |                  |
|                               |                  |
| <b>Siblings:</b>              | <b>Siblings:</b> |
| First Name:                   | First Name:      |
| Last Name:                    | Last Name:       |
| M.I.                          | M.I.             |
| D.O.B.(m/d/y)                 | D.O.B.(m/d/y)    |
| Male/Female                   | Male/Female      |
|                               |                  |
| <b>Siblings:</b>              | <b>Siblings:</b> |
| First Name:                   | First Name:      |
| Last Name:                    | Last Name:       |
| M.I.                          | M.I.             |
| D.O.B.(m/d/y)                 | D.O.B.(m/d/y)    |
| Male/Female                   | Male/Female      |
|                               |                  |
| Parent's Occupation           | Mother:          |
|                               | Father:          |
| Referred by:                  |                  |
| Primary Care Physician:       |                  |
| Address:                      |                  |
|                               |                  |
|                               |                  |
|                               |                  |



**Personal Information (Continued)**

Describe your child to me, including his or her history. Please be as detailed as possible.

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When did you notice your child's problem?

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What did you notice?

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Was the onset of your child's problem sudden or gradual?

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Was there any event or illness that you or others think brought on your child's symptoms?

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Please make note of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be detailed as possible and do not hesitate to mention anything no matter how small or insignificant, that you believe is related to your child's problems.

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**YOUR CHILD'S SLEEPING HABITS:**

How are your child's sleeping habits? Good \_\_\_\_ Bad \_\_\_\_

If bad: Is your child waking at night? \_\_\_\_ or  
 Having trouble falling asleep? \_\_\_\_ Both \_\_\_\_

Other comments: \_\_\_\_\_

| CHILD'S MEDICAL HISTORY |               |            |
|-------------------------|---------------|------------|
| PRIMARY DOCTOR(S)       |               |            |
| NAME                    | PHONE NUMBERS | CITY/STATE |
|                         |               |            |
|                         |               |            |
|                         |               |            |

| THERAPIST(S)                       |                   |       |      |       |            |
|------------------------------------|-------------------|-------|------|-------|------------|
| SPEECH-OCCUPATIONAL-PHYSICAL-OTHER |                   |       |      |       |            |
| NAME                               | TYPE OF THERAPIST | PHONE | CITY | STATE | HOURS/WEEK |
|                                    |                   |       |      |       |            |
|                                    |                   |       |      |       |            |
|                                    |                   |       |      |       |            |

| OTHER CARE GIVERS |       |      |                    |           |
|-------------------|-------|------|--------------------|-----------|
| NAME              | PHONE | CITY | DATE OF EVALUATION | SPECIALTY |
|                   |       |      |                    |           |

**SPECIALIST(S)**

|  |  |  |  |  |
|--|--|--|--|--|
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**NATUROPATH(S)/HOMEOPATH(S)**

|  |  |  |  |  |
|--|--|--|--|--|
|  |  |  |  |  |
|  |  |  |  |  |

**NUTRITIONIST / OTHER**

|  |  |  |  |  |
|--|--|--|--|--|
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|  |  |  |  |  |

| <b>PRENATAL HISTORY</b>  |                                       |                         |
|--|---------------------------------------|-------------------------|
| <b>MATERNAL AGE AT DELIVERY:</b>   | <b>#OF PREGNANCIES / BIRTHS PRIOR</b> | <b>AFTER THIS CHILD</b> |
| <b>ILLNESSES DURING PREGNANCY:</b>   |                                       |                         |
|  |                                       |                         |
|  |                                       |                         |
| <b>MEDICATION DURING PREGNANCY:</b>  |                                       |                         |
|  |                                       |                         |
| <b>HEAVY METAL EXPOSURE DURING PREGNANCY (INCREASED TUNA/SWORDS/FISH/SEA BASS CONSUMPTION; DENTAL WORK: ROOT CANAL, AMALGAMS; FLUVAX; RHOGAN INJECTION</b> |                                       |                         |
|  |                                       |                         |
| <b>OTHER COMPLICATIONS DURING PREGNANCY:</b>   |                                       |                         |
|  |                                       |                         |
| <b>COMPLICATIONS DURING LABOR AND DELIVERY:</b>  |                                       |                         |
|  |                                       |                         |
| <b>MODE OF DELIVERY: C-SECTION/VAGINAL? IF C-SECTION, EXPLAIN WHY?</b>   |                                       |                         |
|  |                                       |                         |
| <b>IF VAGINAL DELIVERY, DID YOU HAVE FORCEPS/VACUUM?</b>   |                                       |                         |
|  |                                       |                         |
| <b>MEDICATION(S) DURING LABOUR AND DELIVERY?</b>   |                                       |                         |
|  |                                       |                         |
| <b>FULL TERM/PREATURE?</b>   | <b>HOW MANY WEEKS?</b>                |                         |
|  |                                       |                         |
| <b>COMPLICATION AFTER DELIVERY?</b>  |                                       |                         |
|  |                                       |                         |
| <b>MEDICATIONS GIVEN TO CHILD DURING HOSPITAL STAY? (INCLUDING IMUNIZATIONS)</b>   |                                       |                         |
|  |                                       |                         |
|  |                                       |                         |

**DIETARY / NUTRITIONAL HISTORY**

|   |                                  |               |
|---|----------------------------------|---------------|
| <b>BREAST-FED?</b>                                    | <b>IF YES, HOW LONG?</b>         | <b>MONTHS</b> |
| <b>BOTTLE-FED?</b>                                    | <b>IF YES, BRAND OF FORMULA?</b> |               |
| <b>BOTTLE FED BEGINNING AT WHAT AGE?</b>              | <b>HOW LONG?</b>                 |               |
| <b>FOODS? BEGUN AT WHAT AGE?</b>                      | <b>FIRST FOODS?</b>              |               |
| <b>KNOW ALLERGIES TO FOOD? (PLEASE LIST)</b>          |                                  |               |
|   |                                  |               |
| <b>SUSPECTED SENSITIVITIES TO FOODS? PLEASE LIST:</b> |                                  |               |
|   |                                  |               |
| <b>FOOD CRAVINGS:</b>                                 |                                  |               |
|   |                                  |               |
|   |                                  |               |

**FOODS MY CHILD EATS: (PLACE AN X IN APPROPRIATE COLUMN)**

| <b>FOOD</b>                           | <b>DAILY</b> | <b>3-5<br/>TIMES<br/>PER<br/>WEEK</b> | <b>1-3<br/>TIMES<br/>PER<br/>WEEK</b> | <b>NEVER OR<br/>ALMOST<br/>NEVER</b> | <b>USED TO EAT A LOT BUT<br/>NO LONGER DOES</b> |
|---------------------------------------|--------------|---------------------------------------|---------------------------------------|--------------------------------------|---|
| <b>COOKIES</b>                        |              |                                       |                                       |                                      |   |
| <b>CANDY</b>                          |              |                                       |                                       |                                      |   |
| <b>SWEET FOODS</b>                    |              |                                       |                                       |                                      |   |
| <b>CAFFEINE<br/>(SODA, TEA, ETC.)</b> |              |                                       |                                       |                                      |   |
| <b>CHOCOLATE</b>                      |              |                                       |                                       |                                      |   |
| <b>MILK: WHOLE</b>                    |              |                                       |                                       |                                      |   |
| <b>2%</b>                             |              |                                       |                                       |                                      |   |
| <b>1%</b>                             |              |                                       |                                       |                                      |   |
| <b>SKIM</b>                           |              |                                       |                                       |                                      |   |
| <b>CHEESE</b>                         |              |                                       |                                       |                                      |   |
| <b>ICE CREAM</b>                      |              |                                       |                                       |                                      |   |
| <b>SALT FOODS</b>                     |              |                                       |                                       |                                      |   |
| <b>MEAT</b>                           |              |                                       |                                       |                                      |   |
| <b>PASTA</b>                          |              |                                       |                                       |                                      |   |
| <b>BREAD: WHITE</b>                   |              |                                       |                                       |                                      |   |
| <b>WHEAT</b>                          |              |                                       |                                       |                                      |   |
| <b>OTHER</b>                          |              |                                       |                                       |                                      |   |

**DIETARY / NUTRITIONAL HISTORY (CONTINUED)**

PLACE AN X IN THE MOST APPROPRIATE DESCRIPTION BELOW OF YOUR CHILD'S DIET:

- MOSTLY BABY FOOD  
 MOSTLY CARBOHYDRATES (BREAD, PASTA, ETC)  
 MOSTLY DAIRY (MILK, CHEESE, ETC)  
 MOSTLY MEAT  
 MOSTLY VEGETARIAN  
 OTHER DESCRIBE:

PLEASE DESCRIBE YOUR CHILD'S STOOL PATTERN (EXAMPLES: DAILY, FOUL, LARGE, MUSHY, ETC)

PLEASE LIST THE FOODS AND BEVERAGES NORMALLY CONSUMED BY YOUR CHILD FOR THREE TYPICAL DAYS:

**DAY 1**

|                  |
|------------------|
| BREAKFAST        |
| MORNING SNACK    |
| LUNCH            |
| AFTERNOON SNACKS |
| DINNER           |
| OTHER            |

**DAY 2**

|                  |
|------------------|
| BREAKFAST        |
| MORNING SNACK    |
| LUNCH            |
| AFTERNOON SNACKS |
| DINNER           |
| OTHER            |

**DAY 3**

|                  |
|------------------|
| BREAKFAST        |
| MORNING SNACK    |
| LUNCH            |
| AFTERNOON SNACKS |
| DINNER           |
| OTHER            |

## FAMILY HISTORY

LIST ANY ALLERGIES, MAJOR ILLNESSES, GENERIC DISEASES, NEUROLOGIC, BIPOLAR, OBSESSIVE COMPULSIVE, DEATHS, OR OTHER PROBLEMS FOR CHILD'S FAMILY MEMBERS.

ANY? Cancer - Tuberculosis – Diabetes - Heart Trouble -High Blood Pressure  
Stroke – Epilepsy - Mental Illness - Suicide

MOTHER:

FATHER:

SIBLINGS:

MATERNAL GRANDPARENTS:

PATERNAL GRANDPARENTS:

OTHERS:

## SOCIAL HISTORY

WHO LIVES IN THE HOME WITH YOUR CHILD?

ANY ADOPTED CHILDREN IN YOUR FAMILY?

PETS IN THE HOUSE?

CAREGIVERS BESIDES PARENTS?

LIST THE PEOPLE MOST IMPORTANT IN YOUR CHILD'S LIFE:

RECENT CHANGES, LOSSES, BIRTHS, DEATHS, DIVORCE, REMARRIAGE, OR MOVES?

RECENT TRAVEL

CHILD'S RESPONSE TO THESE CHANGES:

IS YOUR CHILD INVOLVED IN ANY SPORTS, MUSIC OR OTHER ACTIVITIES? PLEASE DESCRIBE:

HOW DOES YOUR CHILD INTERACT WITH OTHER CHILDREN?

WITH ADULTS?

WHAT MAKES YOUR CHILD HAPPY?

SAD?

ANGRY?

STRESSED?

HOW DO YOU AS A PARENT DEAL WITH THESE EMOTIONS IN YOUR CHILD?

| <b>ENVIRONMENTAL HISTORY</b>  |                         |   |
|---|-------------------------|---|
| <b>DO YOU, YOUR CHILD, OR ANY FAMILY MEMERS PRACTICE ANY RELAXATION, STRESS MANAGEMENT TECHNIQUES? PLEASE DESCRIBE:</b> |                         |   |
| <b>CIRCLE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS AND DESCRIBE:</b>  |                         |   |
| <b>1.) LOCATION OF HOME: CITY / SUBURBAN / WOODED / FARM / OTHER (DESCRIBE):</b>  |                         |   |
| <b>2.) WHAT TYPE OF WATER DOES YOUR FAMILY DRINK?</b>   |                         |   |
| TAP    SPRING    WELL    REVERSED OSMOSIS    DISTILLED    BRITA FILTERED    FRIDGE FILTERED                             |                         |   |
| <b>DO YOU USE LEMON JUICE IN YOUR DRINKING WATER?</b>   |                         |   |
| <b>3.) TYPE OF HEAT: ELECTRIC / GAS / OIL / OTHER (DESCRIBE):</b>   |                         |   |
| <b>4.) DO YOU LIVE NEAR: POWER LINES / WOODS / INDUSTRIAL AREA / WATER</b>  |                         |   |
| <b>5.) IF YOU LIVE NEAR WATER, WHAT TYPE? SWAMP / RIVER / OCEAN / OTHER (DESCRIBE)</b>                                  |                         |   |
| <b>6.) DOES YOUR HOME HAVE A LOT OF: DUST / MOLD / DOWN / OR FEATHER ITEMS? IF SO PLEASE DESCRIBE?</b>                  |                         |   |
| <b>DESCRIBE YOUR CHILD'S BEDROOM:</b>   |                         |   |
| <b>BEDDING: SYNTHETIC / DOWN / FEATHER    MATTRESS ENCLOSED: YES/NO    CRIB/JR. BED / ADULT BED</b>                     |                         |   |
| <b>FLOORING: CARPET: WALL-TO-WALL    AREA RUG    WOOD    GLUED DOWN    SYNTHETIC PAD</b>                                |                         |   |
| <b>WINDOW TREATMENTS: SHADES    BLINDS    THIN CURTAINS    HEAVY CURTAINS    VALANCE    OTHER(DESCRIBE):</b>            |                         |   |
| <b>OTHER ITEMS IN ROOM INCLUDING FURNITURE, TOYS, STUFFED ANIMALS, ETC.:</b>  |                         |   |
| <b>FLOORING IN OTHER ROOMS:</b>   |                         |   |
| <b>CHILD'S BATHROOM:</b>  |                         |   |
| <b>LIVING ROOM?</b>   |                         |   |
| <b>FAMILY ROOM/PLAY ROOM?</b>   |                         |   |
| <b>IS YOUR CHILD SENSITIVE TO OR BOTHERED BY THE FOLLOWING?</b>   |                         |   |
| <b>PERFUMES/COSMETICS?</b>  | <b>MOLD?</b>            | <b>PLEASE LIST ANY OTHER KNOWN ALLERGIES:</b> |
| <b>CLEANING PRODUCTS?</b>   |                         |   |
| <b>POLLENS/GRASSES?</b>   |                         |   |
| <b>SOAPS?</b>   | <b>ANIMALS (DANDER)</b> |   |
| <b>DETERGENTS?</b>  | <b>GASOLINE?</b>        |   |
| <b>DUST?</b>  | <b>PAINT?</b>           |   |
| <b>OTHER?</b>   |                         |   |
|   |                         |   |

## YOUR CHILD'S DEVELOPMENTAL HISTORY

PLEASE LIST THE AGE WHEN THE FOLLOWING SKILLS WERE MASTERED AND ANY PROBLEMS ASSOCIATED WITH THESE SKILLS:

1.) FIRST WORDS:

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2.) PHRASES OR SENTENCE:

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3.) SITTING UP:

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4.) CRAWLING:

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5.) PULLING UP TO A STAND:

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6.) WALKING:

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7.) RUNNING:

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8.) WALKING UP AND DOWN STEPS WITHOUT HELP:

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9.) JUMPING:

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10.) PUT ON CLOTHING

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11.) LEARNED TO PEDAL:

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12.) RODE 2-WHEELED BICYCLE:

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**YOUR CHILD'S MEDICAL HISTORY****PREVIOUS DIAGNOSTIC STUDIES – PLEASE LIST DATES AND RESULTS:**

| <b>PREVIOUS STUDY</b>  | <b>DATE(S)</b> | <b>RESULTS</b> |
|--|----------------|----------------|
| <b>PHYSICAL EXAM</b>   |                |                |
| <b>X-RAYS</b>  |                |                |
| Chest  |                |                |
| Stomach or colon   |                |                |
| Gall bladder   |                |                |
| Extremities  |                |                |
| Back   |                |                |
| Teeth  |                |                |
| <b>HEARING TESTS</b>   |                |                |
| EEG  |                |                |
| EKG  |                |                |
| CT SCAN (BRAIN)  |                |                |
| CT SCAN (OTHER)  |                |                |
| MRI  |                |                |
| <b>LAB WORK</b><br>ATTACH RESULTS IF AVAILABLE<br>ANY ABNORMAL RESULTS |                |                |
| <b>OTHER:</b>  |                |                |
| <b>OTHER:</b>  |                |                |
| <b>OTHER:</b>  |                |                |

| <b>CHILD ILLNESSES – PLEASE LIST APPROPRIATE DATES AND ANY COMPLICATIONS:</b> |                |                      |
|---|----------------|----------------------|
| <b>ILLNESS</b>  | <b>DATE(S)</b> | <b>COMPLICATIONS</b> |
| <b>EAR INFECTIONS</b>   |                |                      |
| <b>SINUS INFECTIONS</b>   |                |                      |
| <b>BRONCHITIS</b>   |                |                      |
| <b>PNEUMONIA</b>  |                |                      |
| <b>THRUSH</b>   |                |                      |
| <b>CHICKEN POX</b>  |                |                      |
| <b>SEIZURES</b>   |                |                      |
| <b>MONO</b>   |                |                      |
| <b>OTHER:</b>   |                |                      |
| <b>OTHER:</b>   |                |                      |
|   |                |                      |

| <b>YOUR CHILD’S MEDICAL HISTORY (CONTINUED)</b>   |                |                |
|---|----------------|----------------|
| <b>MAJOR SURGERIES – PLEASE DESCRIBE AND GIVE DATES:</b>                                  |                |                |
| <b>SURGERY</b>  | <b>DATE(S)</b> | <b>RESULTS</b> |
|   |                |                |
|   |                |                |
|   |                |                |
| <b>Has your child ever been advised to have any operations, which have not been done?</b> |                |                |

| <b>MAJOR INJURIES – PLEASE DESCRIBE AND GIVE DATES:</b> |                |                |
|---|----------------|----------------|
| <b>INJURY</b>   | <b>DATE(S)</b> | <b>RESULTS</b> |
|   |                |                |
|   |                |                |
|   |                |                |

| IMPORTANT – PLEASE PROVIDE COPIES OF MOST RECENT RESULTS OF THE FOLLOWING: 1. BLOOD WORK 2. URINE TESTS 3. STOOL TESTS |  |  |
|--|--|--|
| IMMUNIZATIONS: PLEASE LIST DATES AND ANY COMPLICATIONS:  |  |  |
| DTP/DTaP   |  |  |
| HIB (HEMOPHILUS)   |  |  |
| HEPATITIS B  |  |  |
| OPV/IPV (POLIO)  |  |  |
| VARIVAX (CHICKEN POX)  |  |  |
| MMR (MEASLES)  |  |  |
| ROTAVIRUS VACCINE  |  |  |
| PREVNAR:   |  |  |
| OTHER:   |  |  |
|  |  |  |
| ANY OTHER COMMENTS:  |  |  |
|  |  |  |

| (CHILD IF AVAILABLE) WOMEN ONLY-MENSTRUAL HISTORY |  |  |
|---|--|--|
| Age at onset _____                                |  |  |
| Regular   |  |  |
| Varies  |  |  |
| Cycle _____ days (from start to start)            |  |  |
| FLOW: Heavy      Medium      Light                |  |  |
| Any clots passed                                  |  |  |
| Pains or cramps                                   |  |  |
| Date of last period                               |  |  |
| Date of last pelvic exam                          |  |  |
| Date of last Pap test                             |  |  |
| Results:                      Neg.    Pos.        |  |  |
| Any discharge from vagina? No    Yes              |  |  |
| If so, what color?                                |  |  |
| Amount  |  |  |
| Odor  |  |  |
| Any itching of vaginal area    No    Yes          |  |  |
| Do you take birthcontrol pills? No    Yes         |  |  |
| How long have you taken them?                     |  |  |
| Pregnancies:                                      |  |  |

**YOUR CHILD'S MEDICAL HISTORY (CONTINUED)**

PLEASE LIST APPROXIMATE DATES AND ANY REACTIONS TO ANY MEDICATIONS TAKEN BY YOUR CHILD *IN THE PAST*. IF THE DATES ARE TOO NUMEROUS, JUST LIST THE NUMBER OF TIMES THE MEDICATION WAS GIVEN PER YEAR.

| <b>TYPES OF MEDICATIONS</b>                        | <b>DATE(S)</b> | <b>REACTION(S)</b> | <b>NAME OF DRUG</b> |
|--|----------------|--------------------|---------------------|
| <b>ANTIBIOTICS:</b>                                |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
| <b>SEIZURE MEDICATIONS:</b>                        |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
| <b>ANTI-HISTAMINES:</b>                            |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
| <b>STEROIDS:</b>                                   |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
|  |                |                    |                     |
| <b>ANTIFUNGAL I.E. NYSTATIN, DIFLUCAN, LAMISIL</b> |                |                    |                     |
|  |                |                    |                     |
| Laxatives  |                |                    |                     |
| Appetite Depressants                               |                |                    |                     |
| Anti Depressants                                   |                |                    |                     |
| Thyroid  |                |                    |                     |
| Cortisone  |                |                    |                     |
| Aspirin  |                |                    |                     |
| Sleeping Pills                                     |                |                    |                     |
| Tranquilizers                                      |                |                    |                     |
| Sedatives  |                |                    |                     |

| <b>OTHERS</b> |               |                |                |
|---------------|---------------|----------------|----------------|
| <b>NAME</b>   | <b>DOSAGE</b> | <b>PURPOSE</b> | <b>RESULTS</b> |
|               |               |                |                |
|               |               |                |                |
|               |               |                |                |
|               |               |                |                |
|               |               |                |                |

| <b>YOUR CHILD'S MEDICAL HISTORY (CONTINUED)</b>                                   |               |                              |                                  |
|---|---------------|------------------------------|----------------------------------|
| <b>VITAMINS, MINERALS, SUPPLEMENTS OR OVER THE COUNTER PRODUCTS – PLEASE LIST</b> |               |                              |                                  |
| <b>BRAND NAME (OR<br/>GENERIC)</b>  | <b>DOSAGE</b> | <b>TIME OF DAY<br/>TAKEN</b> | <b>CURRENTLY BEING<br/>TAKEN</b> |
| <b>MULTIVITAMINS</b>  |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
| <b>VITAMIN C</b>  |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
| <b>VITMAIN B</b>  |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
| <b>MAGNESIUM</b>  |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
| <b>CALCIUM</b>  |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
| <b>OTHERS</b>   |               |                              |                                  |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |
|   |               |                              | YES/NO                           |

**HERBAL/HOMEOPATHIC/HOMOTOXICOLOGY AND OR OTHER THERAPIES.  
PLEASE LIST ANY OTHER MEDICATION OF THIS TYPE(S) YOUR CHILD HAS USED.**

| <b>MEDICAL/THERAPY</b> | <b>TIME WHEN TAKEN</b> | <b>EFFECT</b> |
|------------------------|------------------------|---------------|
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |
|                        |                        |               |

| <b>YOUR CHILD'S SIGNS AND SYMPTOMS</b>   |      |          |        |          |                |
|--|------|----------|--------|----------|----------------|
| PLACE AN (X) NEXT TO ANY SIGNS/SYMPTOMS YOUR CHILD MAY DEMONSTRATE AND NOTE DURATION AND DETAILS IS APPROPRIATE. |      |          |        |          |                |
| DESCRIPTION  | MILD | MODERATE | SEVERE | DURATION | UNIQUE DETAILS |
| STIMMING (REPETITIVE ACTIONS)  |      |          |        |          |                |
| ROCKING  |      |          |        |          |                |
| HEAD BANGING   |      |          |        |          |                |
| SELF-MUTILATION  |      |          |        |          |                |
| NAIL BITING  |      |          |        |          |                |
| HAND/ARM BITING  |      |          |        |          |                |
| NAIL/SKIN PICKING  |      |          |        |          |                |
| AGGRESSIVE (HITTING, KICKING, BITING OTHERS)   |      |          |        |          |                |
| MOOD SWINGS  |      |          |        |          |                |
| IRRITABILITY/TANTRUMS  |      |          |        |          |                |
| FEARS/ANXIETIES  |      |          |        |          |                |
| HYPERACTIVITY  |      |          |        |          |                |
| INABILITY TO CONCENTRATE/FOCUS   |      |          |        |          |                |
| FIDGETY IN SEAT  |      |          |        |          |                |
| IMPULSIVE  |      |          |        |          |                |
| DIZZINESS  |      |          |        |          |                |
| SEIZURES   |      |          |        |          |                |
| POOR COORDINATION  |      |          |        |          |                |
| PROBLEMS WITH BUTTONS, TIES, SNAPS, OR ZIPPERS   |      |          |        |          |                |
| PROCESSING PROBLEMS – VISUAL, MOTOR, LANGUAGE, SENSORY, ETC.   |      |          |        |          |                |
| SENSITIVE TO CROWDS  |      |          |        |          |                |
| TROUBLE REMEMBERING  |      |          |        |          |                |
| LOW SELF-ESTEEM  |      |          |        |          |                |
| FATIGUE  |      |          |        |          |                |
| COLDS HANDS/FEET   |      |          |        |          |                |
| COLD INTOLERANCE   |      |          |        |          |                |
| RECURRENT/CHRONIC FEVER  |      |          |        |          |                |
| FLUSHING   |      |          |        |          |                |
| EXCESSIVE SWEATING   |      |          |        |          |                |
| DIFFICULTY FALLING ASLEEP  |      |          |        |          |                |
| NIGHT WAKING   |      |          |        |          |                |
| NIGHTMARES   |      |          |        |          |                |
| DIFFICULTY WAKING  |      |          |        |          |                |
| BED WETTING/SOILING  |      |          |        |          |                |
| DAYTIME WETTING/SOILING  |      |          |        |          |                |
| NUMBNESS/TINGLING HANDS AND FEET   |      |          |        |          |                |
| HEADACHE   |      |          |        |          |                |
| BLINKING   |      |          |        |          |                |
| STARING  |      |          |        |          |                |

| DESCRIPTION                           | MILD | MODERATE | SEVERE | DURATION | UNIQUE DETAILS |
|---------------------------------------|------|----------|--------|----------|----------------|
| DARK CIRCLES/PUFFINESS UNDER THE EYES |      |          |        |          |                |
| EYE DISCHARGE                         |      |          |        |          |                |
| NIGHT-BLINDNESS IN CHILD/FAMILY       |      |          |        |          |                |
| CONGESTION                            |      |          |        |          |                |
| DRIPPING NOSE                         |      |          |        |          |                |
| SENSITIVITY TO BRIGHT LIGHTS          |      |          |        |          |                |
| EARACHES                              |      |          |        |          |                |
| RINGING IN EARS                       |      |          |        |          |                |
| SENSITIVE TO SOUNDS/NOISE             |      |          |        |          |                |
| BAD BREATH                            |      |          |        |          |                |
| NOSE BLEEDS                           |      |          |        |          |                |
| ACUTE SENSE OF SMELL                  |      |          |        |          |                |
| HOARSENESS                            |      |          |        |          |                |
| SORE THROATS                          |      |          |        |          |                |
| COUGH                                 |      |          |        |          |                |
| WHEEZING                              |      |          |        |          |                |
| GEOGRAPHICAL TONGUE                   |      |          |        |          |                |
| SWOLLEN GUMS                          |      |          |        |          |                |
| CANKER SORES                          |      |          |        |          |                |
| DRY LIPS/MOUTH                        |      |          |        |          |                |
| DIARRHEA                              |      |          |        |          |                |
| CONSTIPATION                          |      |          |        |          |                |
| FOUL-SMELLING STOOLS                  |      |          |        |          |                |
| BLOATING                              |      |          |        |          |                |
| PASSING GAS                           |      |          |        |          |                |
| BELCHING                              |      |          |        |          |                |
| STOMACHACHE                           |      |          |        |          |                |
| REFUSAL TO EAT                        |      |          |        |          |                |
| SENSITIVE TO TEXTURE OF FOOD          |      |          |        |          |                |
| DIFFICULTY SWALLOWING                 |      |          |        |          |                |
| FOOD CRAVING                          |      |          |        |          |                |
| GRINDING TEETH                        |      |          |        |          |                |
| MUCOUS/BLOOD IN STOOLS                |      |          |        |          |                |
| ANAL ITCHING                          |      |          |        |          |                |
| MUSCLE CRAMPS                         |      |          |        |          |                |
| TREMORS                               |      |          |        |          |                |
| WEAKNESS                              |      |          |        |          |                |
| STIFFNESS                             |      |          |        |          |                |
| ECZEMA                                |      |          |        |          |                |
| PSORIASIS                             |      |          |        |          |                |
| HIVES                                 |      |          |        |          |                |
| ACNE                                  |      |          |        |          |                |
| SEBORRHEA (CRADLE CAP)                |      |          |        |          |                |

| DESCRIPTION                     | MILD | MODERATE | SEVERE | DURATION | UNIQUE DETAILS |
|---------------------------------|------|----------|--------|----------|----------------|
| OTHER RASHES                    |      |          |        |          |                |
| EASY BRUISING                   |      |          |        |          |                |
| ITCHY SCALP                     |      |          |        |          |                |
| DRY SKIN / OILY SKIN            |      |          |        |          |                |
| PALE SKIN                       |      |          |        |          |                |
| SENSITIVITY TO INSECT BITES     |      |          |        |          |                |
| SENSITIVE TO TEXTURE OF CLOTHES |      |          |        |          |                |
| CRACKING/PEELING HANDS          |      |          |        |          |                |
| CRACKING PEELING FEET           |      |          |        |          |                |
| STRONG BODY ODOR                |      |          |        |          |                |
| SOFT NAILS                      |      |          |        |          |                |
| THICKENING OF NAILS             |      |          |        |          |                |
| RIDGES/PITTING OF NAILS         |      |          |        |          |                |
| WHITE SPOTS/LINES ON NAILS      |      |          |        |          |                |
| BRITTLE NAILS                   |      |          |        |          |                |
| TICS                            |      |          |        |          |                |

| <b>Has your child ever had?</b>     |            |           |                       |
|-------------------------------------|------------|-----------|-----------------------|
| <b>Please check yes or no.</b>      | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |
| <b>Measles</b>                      |            |           |                       |
| <b>German measles</b>               |            |           |                       |
| <b>Mumps</b>                        |            |           |                       |
| <b>Chicken pox</b>                  |            |           |                       |
| <b>Whooping cough</b>               |            |           |                       |
| <b>Scarlet fever or Scarlentina</b> |            |           |                       |
| <b>Diphtheria</b>                   |            |           |                       |
| <b>Small pox</b>                    |            |           |                       |
| <b>Pneumonia</b>                    |            |           |                       |
| <b>Influenza</b>                    |            |           |                       |
| <b>Pleurisy</b>                     |            |           |                       |
| <b>Rheumatic Fever</b>              |            |           |                       |
| <b>Any bone or joint disease</b>    |            |           |                       |
| <b>Neuritis or neuralgia</b>        |            |           |                       |
| <b>Bursitis</b>                     |            |           |                       |
| <b>Sciatica</b>                     |            |           |                       |
| <b>Lumbago</b>                      |            |           |                       |
| <b>Polio or Meningitis</b>          |            |           |                       |
| <b>Nephritis</b>                    |            |           |                       |
| <b>Gonorrhea or Syphilis</b>        |            |           |                       |
| <b>Gallbladder disease</b>          |            |           |                       |
| <b>Anemia</b>                       |            |           |                       |
| <b>Jaundice</b>                     |            |           |                       |
| <b>Bladder disease</b>              |            |           |                       |

| <b>Has your child ever had? Continued.</b>           |            |           |                       |
|--|------------|-----------|-----------------------|
| <b>Please check yes or no.</b>                       | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |
| Epilepsy   |            |           |                       |
| Migraine headaches                                   |            |           |                       |
| Tuberculosis   |            |           |                       |
| Diabetes   |            |           |                       |
| Cancer   |            |           |                       |
| High or low blood pressure                           |            |           |                       |
| Colitis or other bowel diseases                      |            |           |                       |
| Hemorrhoids or any rectal dis.                       |            |           |                       |
| Nervous breakdown                                    |            |           |                       |
| Food, chemical or drug poisoning                     |            |           |                       |
| Hay fever or asthma                                  |            |           |                       |
| Hives or Eczema                                      |            |           |                       |
| Frequent infections or boils                         |            |           |                       |
| <b>INJURIES: have you had any?</b>                   |            |           |                       |
| Broken or cracked bones                              |            |           |                       |
| Sprains  |            |           |                       |
| Lacerations  |            |           |                       |
| Dislocations   |            |           |                       |
| Concussion, or head injuries                         |            |           |                       |
| Ever been knocked unconscious                        |            |           |                       |
| Frequent or severe headaches                         |            |           |                       |
| Fainting spells                                      |            |           |                       |
| Dizziness on movement                                |            |           |                       |
| Unconscious spells                                   |            |           |                       |
| Blurred vision                                       |            |           |                       |
| Double vision  |            |           |                       |
| Spots in front of the eyes                           |            |           |                       |
| Infected eyes  |            |           |                       |
| Pain behind eyes                                     |            |           |                       |
| Any change in vision                                 |            |           |                       |
| Do you wear glasses?<br>When was your last check up? |            |           |                       |
| Earaches   |            |           |                       |
| Discharge from ears                                  |            |           |                       |
| Ringling in ears                                     |            |           |                       |
| Diminishing of hearing                               |            |           |                       |
| Recurrent nose bleed                                 |            |           |                       |
| Recurrent head colds                                 |            |           |                       |
| Sinus trouble  |            |           |                       |
| Hay fever  |            |           |                       |
| Strange persistent odors                             |            |           |                       |
| Persistent hoarseness                                |            |           |                       |
| Difficulty on swallowing                             |            |           |                       |
| <b>Has your child ever had? Continued.</b>           |            |           |                       |
| <b>Please check yes or no.</b>                       | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |

|   |  |  |  |
|---|--|--|--|
| Enlarged glands                               |  |  |  |
| Recurrent sore throats                        |  |  |  |
| Recurrent mouth sores                         |  |  |  |
| Soreness or bleeding of gums during brushing. |  |  |  |

| <b>Has your child ever had in the last year? Please check yes or no.</b> |            |           |                       |
|--|------------|-----------|-----------------------|
| <b>PROBLEM</b>   | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |
| Chest pain   |            |           |                       |
| Angina pectoris  |            |           |                       |
| Coughed up blood   |            |           |                       |
| Pain in arm(s)   |            |           |                       |
| Night sweats   |            |           |                       |
| Chronic or frequent cough  |            |           |                       |
| Chronic or frequent cough on lying down                                  |            |           |                       |
|  |            |           |                       |
| Wake up short of breath  |            |           |                       |
| Shortness of breath on:  |            |           |                       |
| Walking several blocks   |            |           |                       |
| One flight of stairs   |            |           |                       |
| On lying down  |            |           |                       |
|  |            |           |                       |
| Purple lips or fingers   |            |           |                       |
| Palpitations, fluttering of heart  |            |           |                       |
| High blood pressure  |            |           |                       |
| Swelling of hands, feet or ankles.                                       |            |           |                       |
| At what time of day  |            |           |                       |
|  |            |           |                       |
| Leg cramps on walking or at night  |            |           |                       |
| Enlarged veins in legs   |            |           |                       |
| Recurrent stomach pain   |            |           |                       |

| <b>Has your child ever had in the last year? Please check yes or no. Continued.</b> |            |           |                       |
|---|------------|-----------|-----------------------|
| <b>PROBLEM</b>  | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |
| Belching or heartburn<br>Relieved by food or medication.                            |            |           |                       |
| Appetite: good<br>fair poor   |            |           |                       |
| Nausea or vomiting  |            |           |                       |
| Avoid some foods  |            |           |                       |
| What kinds?   |            |           |                       |
| Avoid spices  |            |           |                       |
| Like some foods<br>very much  |            |           |                       |
| What kinds?   |            |           |                       |
| Abdominal<br>cramping   |            |           |                       |
| Color of bowel<br>movement.   |            |           |                       |
| Consistency of<br>stools  |            |           |                       |
| Frequency of BM a<br>day/week   |            |           |                       |
| Any blood in bowel<br>movement  |            |           |                       |
| Rectal pain with<br>B.M.  |            |           |                       |
| Change in size<br>shape or texture<br>of B.M.                                       |            |           |                       |
| Do you get up at<br>night to urinate  |            |           |                       |
| How many times?   |            |           |                       |
| Pain on urinating?  |            |           |                       |
| Difficulty in starting<br>urination?<br>Urinate more than<br>before?                |            |           |                       |
| Urinate less than<br>before   |            |           |                       |
| Any blood in urine  |            |           |                       |
| How much water do<br>you drink a day  |            |           |                       |
| How many times per<br>day do you urinate?   |            |           |                       |
| Full feeling of<br>bladder but only   |            |           |                       |
| Small amount of<br>urination  |            |           |                       |
| Lose urine on<br>coughing or sneezing   |            |           |                       |
| Discharge from<br>penis   |            |           |                       |

| <b>Has your child ever had in the last year? Please check yes or no. Continued.</b> |            |           |                       |
|---|------------|-----------|-----------------------|
| <b>PROBLEM</b>  | <b>YES</b> | <b>NO</b> | <b>OTHER COMMENTS</b> |
| Recurrent back pains  |            |           |                       |
| Backaches   |            |           |                       |
| Joint pains   |            |           |                       |
| Swelling of any joints  |            |           |                       |
| Redness or heat of any joint  |            |           |                       |
| Tingling or weakness of hands or feet   |            |           |                       |
| Muscle spasm  |            |           |                       |
| Loss or change in sensation of hands or feet  |            |           |                       |
| Trembling of any extremity  |            |           |                       |
| Growth in neck or throat  |            |           |                       |
| Hot flashes   |            |           |                       |
| Tiredness without apparent reason?  |            |           |                       |
| Brittleness of nails  |            |           |                       |
| Dryness of skin   |            |           |                       |
| Easy bruising   |            |           |                       |
| Inability to stand heat   |            |           |                       |
| Inability to stand cold   |            |           |                       |
| Change in hair texture  |            |           |                       |
| Change in skin texture  |            |           |                       |
| Any skin rash   |            |           |                       |
|   |            |           |                       |

| <b>YOUR CHILD'S SIGNS AND SYMPTOMS</b>   |
|--|
| <b>DESCRIBE ANY OTHER SYMPTOMS YOU WOULD LIKE ME TO KNOW ABOUT YOUR CHILD:</b>           |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
| <b>LIST ANY OTHER HISTORY, PERTINENT THOUGHTS OR QUESTIONS THAT YOU WANT TO ADDRESS:</b> |
|  |
|  |
|  |
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|  |

| <b>NUMBER OF COMMON PROBLEMS THAT CHILDREN HAVE.</b>                 |  |          |          |          |          |
|--|--|----------|----------|----------|----------|
| <b>MARK AN X IN THE RATE ACCORDING TO THE LAST MONTH:</b>            |  |          |          |          |          |
| <b>0-NONE            1&amp;2- IN BETWEEN            3-FREQUENTLY</b> |  |          |          |          |          |
|  | <b>PROBLEM</b>   | <b>0</b> | <b>1</b> | <b>2</b> | <b>3</b> |
| 1  | ANGRY AND RESENT   |          |          |          |          |
| 2  | DIFFICULTY DOING OR COMPLETING HOMEWORK  |          |          |          |          |
| 3  | IS ALWAYS "ON THE GO" OR ACTS AS IF DRIVEN BY A MOTOR  |          |          |          |          |
| 4  | TIMID, EASILY FRIGHTENED   |          |          |          |          |
| 5  | EVERYTHING MUST BE JUST SO   |          |          |          |          |
| 6  | HAS NO FRIENDS   |          |          |          |          |
| 7  | STOMACH ACHES  |          |          |          |          |
| 8  | FIGHTS   |          |          |          |          |
| 9  | AVOIDS, EXPRESSES RELUCTANCE ABOUT, OR HAS DIFFICULTIES ENGAGING IN TASKS THAT REQUIRE SUSTAINED MENTAL EFFORT (SUCH AS SCHOOLWORK OR HOMEWORK)                                    |          |          |          |          |
| 10   | HAS DIFFICULTY SUSTAINING ATTENTION IN TASKS OR PLAY ACTIVITIES  |          |          |          |          |
| 11   | ARGUES WITH ADULTS   |          |          |          |          |
| 12   | FAILS TO COMPLETE ASSIGNMENTS  |          |          |          |          |
| 13   | HARD TO CONTROL IN MALLS OR WHILE GROCERY SHOPPING   |          |          |          |          |
| 14   | AFRAID OF PEOPLE   |          |          |          |          |
| 15   | KEEPS CHECKING THINGS OVER AND OVER AGAIN  |          |          |          |          |
| 16   | LOSES FRIENDS QUICKLY  |          |          |          |          |
| 17   | ACHES AND PAINS  |          |          |          |          |
| 18   | RESTLESS OR OVERACTIVE   |          |          |          |          |
| 19   | HAS TROUBLE CONCENTRATING IN CLASS   |          |          |          |          |
| 20   | DOES NOT SEEM TO LISTEN TO WHAT IS BEING SAID TO HIM/HER   |          |          |          |          |
| 21   | LOSES TEMPER   |          |          |          |          |
| 22   | NEEDS CLOSE SUPERVISION TO GET THROUGH ASSIGNMENTS   |          |          |          |          |
| 23   | RUNS ABOUT OR CLIMBS EXCESSIVELY IN SITUATIONS WHERE IT IS INAPPROPRIATE   |          |          |          |          |
| 24   | AFRAID OF NEW SITUATIONS   |          |          |          |          |
| 25   | FUSSY ABOUT CLEANLINESS  |          |          |          |          |
| 26   | DOES NOT KNOW HOW TO MAKE FRIENDS  |          |          |          |          |
| 27   | GETS ACHES AND PAINS OR STOMACHACHES BEFORE SCHOOL   |          |          |          |          |
| 28   | EXCITABLE, IMPULSIVE   |          |          |          |          |
| 29   | DOES NOT FOLLOW THROUGH ON INSTRUCTIONS AND FAILS TO FINISH SCHOOLWORK, CHORES OR DUTIES IN THE WORKPLACE (NOT DUE TO OPPOSITIONAL BEHAVIOR OR FAILURE TO UNDERSTAND INSTRUCTIONS) |          |          |          |          |
| 30   | HAS DIFFICULTY ORGANIZING TASKS AND ACTIVITIES   |          |          |          |          |
| 31   | IRRITABLE  |          |          |          |          |
| 32   | RESTLESS IN THE "SQUIRMY SENSE"  |          |          |          |          |
| 33   | AFRAID OF BEING ALONE  |          |          |          |          |
| 34   | THINGS MUST BE DONE THE SAME WAY EVERY TIME  |          |          |          |          |
| 35   | DOES NOT GET INVITED OVER TO FRIENDS HOUSES  |          |          |          |          |

|    | PROBLEM Cont'd  | 0 | 1 | 2 | 3 |
|----|---|---|---|---|---|
| 36 | HEADACHES   |   |   |   |   |
| 37 | FAILS TO FINISH THINGS HE/SHE STARTS  |   |   |   |   |
| 38 | INATTENTIVE, EASILY DISTRACTED  |   |   |   |   |
| 39 | TALKS EXCESSIVELY   |   |   |   |   |
| 40 | ACTIVELY DEFIES OR REFUSES TO COMPLY WITH ADULTS REQUESTS   |   |   |   |   |
| 41 | FAILS TO GIVE CLOSE ATTENTION TO DETAILS OR MAKES CARELESS MISTAKES IN SCHOOLWORK, WORK OR OTHER ACTIVITIES |   |   |   |   |
| 42 | HAS DIFFICULTY WAITING IN LINES OR AWAITING TURN IN GAMES OR GROUP SITUATIONS                               |   |   |   |   |
| 43 | HAS A LOT OF FEARS  |   |   |   |   |
| 44 | HAS RITUALS THAT HE/SHE MUST GO THROUGH   |   |   |   |   |
| 45 | DISTRACTIBILITY OR ATTENTION SPAN A PROBLEM   |   |   |   |   |
| 46 | COMPLAINS ABOUT BEING SICK EVEN WHEN NOTHING IS WRONG   |   |   |   |   |
| 47 | TEMPER OUTBURSTS  |   |   |   |   |
| 48 | GETS DISTRACTED WHEN GIVEN INSTRUCTIONS TO DO SOMETHING   |   |   |   |   |
| 49 | INTERRUPTS OR INTRUDES ON OTHERS (E.G. BUTTS INTO OTHERS CONVERSATIONS OR GAMES)                            |   |   |   |   |
| 50 | FORGETFUL IN DAILY ACTIVITIES   |   |   |   |   |
| 51 | CANNOT GRASP ARITHMETIC   |   |   |   |   |
| 52 | WILL RUN AROUND BETWEEN MOUTHFULS AT MEALS  |   |   |   |   |
| 53 | AFRAID OF THE DARK, ANIMALS OR BUGS   |   |   |   |   |
| 54 | SETS VERY HIGH GOALS FOR SELF   |   |   |   |   |
| 55 | FIDGETS WITH HANDS OR FEET OR SQUIRMS IN SEAT   |   |   |   |   |
| 56 | SHORT ATTENTION SPAN  |   |   |   |   |
| 57 | TOUCHY OR EASILY ANNOYED BY OTHERS  |   |   |   |   |
| 58 | HAS SLOPPY HANDWRITING  |   |   |   |   |
| 59 | HAS DIFFICULTY PLAYING OR ENGAGING IN LEISURE ACTIVITIES QUIETLY  |   |   |   |   |
| 60 | SHY, WITHDRAWN  |   |   |   |   |
| 61 | BLAMES OTHERS FOR HIS/HER MISTAKES OR BEHAVIOUR   |   |   |   |   |
| 62 | FIDGETING   |   |   |   |   |
| 63 | MESSY OR DISORGANIZED AT HOME OR SCHOOL   |   |   |   |   |
| 64 | GETS UPSET IF SOMEONE REARRANGES HIS/HER THINGS   |   |   |   |   |
| 65 | CLINGS TO PARENTS OR OTHER ADULTS   |   |   |   |   |
| 66 | DISTURBS OTHER CHILDREN   |   |   |   |   |
| 67 | DELIBERATELY DOES THINGS THAT ANNOY OTHER PEOPLE  |   |   |   |   |
| 68 | DEMANDS MUST BE MET IMMEDIATELY-EASILY FRUSTRATED   |   |   |   |   |
| 69 | ONLY ATTENDS IF IT IS SOMETHING HE/SHE IS VERY INTERESTED   |   |   |   |   |
| 70 | SPITEFUL OR VINDICTIVE  |   |   |   |   |
| 71 | LOSES THINGS NECESSARY FOR TASKS OR ACTIVITIES (E.G. SCHOOL ASSIGNMENTS, PENCILS, BOOKS, TOOLS OR TOYS)     |   |   |   |   |
| 72 | FEELS INFERIOR TO OTHERS  |   |   |   |   |

|    | PROBLEM Cont'd  | 0 | 1 | 2 | 3 |
|----|---|---|---|---|---|
| 73 | SEEMS TIRED OR SLOWED ALL THE TIME  |   |   |   |   |
| 74 | SPELLING IS POOR  |   |   |   |   |
| 75 | CRIES OFTEN AND EASILY  |   |   |   |   |
| 76 | LEAVES SEAT IN CLASSROOM OR IN OTHER SITUATIONS IN WHICH REMAINING SEATED IS EXPECTED |   |   |   |   |
| 77 | MOOD CHANGES QUICKLY AND DRASTICALLY  |   |   |   |   |
| 78 | EASILY FRUSTRATED IN EFFORTS  |   |   |   |   |
| 79 | EASILY DISTRACTED BY EXTRANEOUS STIMULI   |   |   |   |   |
| 80 | BLURTS OUT ANSWERS TO QUESTIONS BEFORE THE QUESTIONS HAVE BEEN COMPLETED              |   |   |   |   |

| <b>OTHER QUESTIONS WE FEEL ARE IMPORTANT TO ASK?</b>   |               |
|--|---------------|
| <b>PLEASE LIST ANY HOBBIES YOUR CHILD HAS, RECREATIONAL OR LEISURE ACTIVITIES / EXERCISE HE/SHE PERFORMS:</b>  |               |
|  |               |
| <b>DOES YOUR CHILD MEDITATE OR DO RELAXATION EXERCISES REGULARLY? NO YES</b>   |               |
|  |               |
| <b>Does your child have any pets?</b>  | <b>No Yes</b> |
| <b>IF YES, WHAT TYPE OF PETS DO YOU HAVE?</b>  |               |
|  |               |
| <b>IS YOUR CHILD A VEGETARIAN? NO ____ YES ____</b>  |               |
|  |               |
| <b>DIET: Is your CHILD'S diet primarily of typical North American food NO ____ YES ____</b><br>If no, please list anything unusual about your diet _____ |               |
|  |               |
| <b>Does your child have any Religious Affiliations to food?</b><br><b>NO ____ YES ____ If yes, what? _____</b>   |               |
| <b>OR</b>  |               |
| <b>Medical Procedures?</b><br><b>NO ____ YES ____ If yes, what? _____</b>  |               |
|  |               |
| <b>DOES YOUR CHILD PREFER DIET DRINKS OR POP WITH ARTIFICIAL SWEETENERS?</b><br><b>NO YES If yes, what sort of sweeteners?</b>                           |               |
|  |               |
|  |               |

| <b>OTHER QUESTIONS WE FEEL ARE IMPORTANT TO ASK? Cont'd</b>                                       |
|---|
| <b>PLEASE LIST ALL YOUR CHILD'S MAJOR SOURCES OF STRESS OR THINGS THAT CAUSE HIM/HER ANXIETY.</b> |
|   |
|   |
| <b>HAS YOUR CHILD EVER SMOKED?</b>  |
|   |
| <b>DOES YOUR CHILD DRINK COFFEE, TEA OR ALCOHOL?</b>  |
|   |
|   |

| <b>IS THERE ANYTHING ELSE THAT YOU FEEL IS IMPORTANT; AND HAS NOT BEEN ASKED?</b> |
|---|
| <b>IF SO, PLEASE FEEL FREE TO SHARE IT WITH US:</b>                               |
|   |
|   |
|   |
|   |
|   |
|   |
|   |
|   |

## **ABOUT THE VISIT**

At the first visit the practitioner will meet with the parent(s) / caregiver first. The practitioner needs the time and concentration to speak to the parents first. There will be a second visit with the child, so that the practitioner can really take some one on one time with your child and do an evaluation. Thank you for choosing Okotoks Natural Health Centre for your child's health needs, please do not hesitate to call if you have any questions or concerns. Please call the office for the pricing and length of time for the visits.

When the practitioner meets with the child and then takes time to start the Healing Program we ask that after you start your plan you should come in 10-14 days for a follow-up visit to verify the healing process. We will then evaluate how everything is going and talk about the success of the plan.

## **IRIDODOLOGY**

Iridology identifies inherited predispositions that negatively or positively can affect one's health, as the iris shows, which systems of the body are the least and which are the most resilient.

Iridology is a diagnostic tool that helps the Practitioner see certain signs out of the iris, every bodily organ corresponds to a location on the iris, which then makes it possible to find out where the problems are originating.

Iridology is an invaluable tool for prevention; we need to identify our strongest functioning parts of the body, so we can depend upon them to carry us through periods of stress, and to keep the body balanced and in harmony!

**Homeopathy:** is a system of medicine that uses highly diluted doses from the plant, mineral and animal kingdoms to stimulate natural defenses in the body. Homeopathic remedies are based on the theory that "like cures like," and uses remedies that cause symptoms of a certain illness in one who is healthy in order to stimulate the body's natural defenses to heal those same symptoms in one who is ill. The word homeopathy comes from the Greek word 'homeos' meaning similar, and 'pathos' meaning suffering.

**Herbal Medicine:** is the therapeutic use of plants, and is the most ancient form of health care known to humankind. A herb is a plant or plant part valued for its medicinal, savory or aromatic qualities. Herb plants produce and contain a variety of chemical substances that act upon the body. Herbs have been used to treat virtually every disease and condition. The use of herbology ranges from pain relievers, hormone balancers, energizers, sleep aids, stomach soothers, skin soothers, and treatment of everything from allergies to cancer, from depression to hysteria. Herbs are used for both prevention and treatment.

**Homotoxicology:** In homotoxicology, homotoxins are all of those substances, which can cause ill health in humans. They can be introduced from the exterior or originate in the body itself. In Homotoxicology, homeopathically manufactured combination products are designed to work with the body's defense mechanisms and facilitate the body's elimination of toxic substances.

### **VERY IMPORTANT NOTICE:**

**WE WOULD LIKE TO HEAR HOW YOU FEEL DURING THE TREATMENT, PLEASE CALL US A WEEK AFTER YOU HAVE STARTED THE TREATMENT.**

**THIS SUGGESTION PLAN IS NOT INTENDED TO REPLACE YOUR MEDICATION FROM YOUR GENERAL MEDICAL PRACTITIONER.**

**DO NOT TAKE ANY OTHER SUPPLEMENTS OR DO NOT CHANGE THE RECOMMENDED DOSAGE IN OUR PROGRAM UNLESS DISCUSSED WITH THE PRACTITIONER(S).**

**FINANCIAL POLICY**

**THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE THAT YOU READ AND SIGN PRIOR TO ANY SUGGESTIONS. ALL PATIENTS MUST COMPLETE OUR “QUESTIONNAIRE” BEFORE BEING SEEN AT OUR OFFICE(S). FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, DEBIT, VISA OR MASTERCARD.**

**PLEASE NOTE THAT WE DO NOT FILE FOR INSURANCE. THE BILL IS YOUR RESPONSIBILITY, WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. PLEASE BE AWARE THAT SOME, PERHAPS ALL, OF THESE SERVICES PROVIDED MAY BE “NON-COVERED” SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL, REGARDLESS OF YOUR INSURANCE COVERAGE.**

**CANCELLATION POLICY**

**UNLESS APPOINTMENTS ARE CANCELLED AT LEAST 72 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT NORMAL OFFICE RATES. IF CANCELLED ON A FRIDAY AFTER 1:00 PM OR OVER THE WEEKEND YOU WILL ALSO BE CHARGED AT NORMAL OFFICE RATES.**

**THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS. I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

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\_\_\_\_\_  
**SIGNATURE PATIENT/RESPONSIBLE PARTY**

\_\_\_\_\_  
**DATE (m/d/y)**