CHILDREN'S CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Parents:
Welcome. It is our hope that we can assist you with your current and future health concerns. Our focus is: health improvement, maintenance, prevention and education. Any current health problems may be indicators of underlying imbalances. Part of our job will be to explore your child's overall health status and advise you on measures to ensure optimal well being.

During the course of your child's examination and treatments, please feel free to comment, ask questions, and provide us with feedback. We feel that the more you know about wellness, the more active a role you can play in restoring and maintaining your child's health.

Please complete this questionnaire with care on behalf of your child. Your answers will help us to determine the most effective health care for your child.

Name:		Date:	
Mother's Name:		Father's Name:	
Phone (H):	Alternate Phone (Mother):	Alternate Phone (Father):	
Address:	City:		Postal Code:
DOB:	Age	Weight	Height

How did you hear about Dr Christine? **Please check all that apply:**

	Current Client of Clinic		Building Sign		Canada 411
	Business Cards/Flyers		Yellow Pages		Yellow Pages.ca
	Internet		Yahoo		Bing
	Google		Referral (Please state Who)		Other (Please Explain)

What is your chief concern about your child's health?
What else would you like to see changed in their health?
If there is a specific condition, how long has it been occurring?
List any practioners seen for this condition:
List diagnosis, types of treatments, medications etc.
Is there a relative with similar problems? ____ Yes ___ No; If Yes, who?

Has your child had x-rays taken in the last three years? ____ Yes ____ No Please list areas:
Has your child lost any days at school recently ____ Yes ____ No Dates:
Why do you fee is causing your child's health problems?
When was your child last well?
Does your child have regular sleep habits ____ Yes ____ No How many hours?
Early riser? ___ Yes ___ No Difficulty falling asleep? ____ Yes ____ No Nightmares/Night terrors? ____ Yes ____ No

Please list any vaccinations your child has had, include age, and any adverse reactions they experienced?

Vaccination	Age	Adverse Reaction

Please indicate which of the following childhood diseases your child has had? Please indicate if it was mild average or severe.

	Yes or No	Age	Severity: Mild, Average or Severe
Roseola			
Rubella/German Measles			
Rubeola/Measles			
Chicken Pox			
	Yes or No	**Age**	**Severity: Mild, Average or Severe**
Scarlet Fever			
Pertussis/Whooping Cough			
Strep Throat			
Impetigo			
Mononucleosis			
Mumps			

Please indicate the occurrence of the following, along with details and dates:

Surgery:_____ Hospitalization: _____
_____ _____
_____ _____

Accident: _____ Major Illness: _____
_____ _____
_____ _____

Loss of Consciousness: _____ Seizures: _____
_____ _____
_____ _____

Is there a history of any of the following in your family (Please circle and state relationship of family member:

Alcoholism	Cancer	Heart Disease	Schizophrenia
Allergies	Cataracts	Hyperactivity	Stomach Ulcers
Arteriosclerosis	Celiac	Kidney Disease	Stroke
Arthritis	Colitis	Learning Disability	Tuberculosis
Asthma	Depression	Mental Disease	Yeast Infections
Bed Wetting	Diabetes	Muscular Dystrophy	Venereal Disease
Candida Albicans	Epilepsy	Multiple Sclerosis	

What was the level of health for both parents prior to conception?

Father: ____ Poor ____ Fair ____Good ____Excellent

Mother: ____ Poor ____ Fair ____Good ____Excellent

What was the level of health of the mother during pregnancy?

____ Poor ____ Fair ____Good ____Excellent

Comments:

What supplements/vitamins was the mother taking during pregnancy?

What medications did the mother take during pregnancy?

Prescription:

Over the Counter:

Did the mother smoke before pregnancy? ____ Yes ____ No

If Yes how many cigarettes per day? ____

Does anyone in the household currently smoke? ____ Yes ____No

If yes indicate beverage amount and frequency ?

The mother's diet during the pregnancy was?____ Poor____ Fair ____Good ____Excellent

What was the mother's emotional state during pregnancy?

____ Excellent ____ Stable ____Stressed ____ Very Stressed

What is the emotional climate of the child's home presently:

____ Excellent ____ Stable ____Stressed ____ Very Stressed

How was the birth of the child?

Indicate if the was a Caesarian section, forceps, or any complications:

Has your child had colic? ____ Yes ____ No Was your child breast-fed ____ Yes ____ No

If Breast-fed, for how long? What type of formula was given?

What solid foods were started prior to 6 months of age?

Food	**Age**

What additional foods were introduced between 6 to 9 months of age?

Food	**Age**

List child's favorite foods:

Please list what is typical: Breakfast:	Lunch:	Dinner:

Your child's appetite is:

____ Poor ____Fair ____Good ____Excellent

What supplements/vitamins does your child take on a regular basis?

What are your observations about your Childs temperament?

Is your child's physical development?

____ slower than average ____ average ____ faster than average

How is your child's behavior and performance at school?

What form of heat do you presently have? ____ Oil ____ Electric ____ Gas

Are there any pets in household? ____ Yes ____ No

If yes, what kind?

INFORMED CONSENT STATEMENT

THIS FORM MUST BE SIGNED BEFORE ANY TREAMENT WILL BE RENDERED

Naturopathic medicine uses non–invasive methods of assessing the bodily functions and the use of natural therapeutic for correction. The methods used by Christine Slonetsky, N.D. include homeopathy, clinical nutrition, botanical medicine, traditional Chinese medicine and acupuncture, counselling, and various modes of physical therapy. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I, Christine Slonetsky, N.D., ask for your cooperation in signing this statement of acknowledgement, in so doing:

1. That you understand that I am a Naturopathic Doctor, and not a conventional medical doctor, that I use non-invasive, natural methods as assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.
2. That you understand the methods that I may use have proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.
3. That you understand that I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.
4. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
5. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.
6. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions.
7. That while changes in dietary habits are not an absolute pre-requisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
8. That you are accepting or rejecting this care of your own free will.
9. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectation and what I can provide are not in agreement.
10. That you understand that all fees for services and supplements are payable at the time of the appointment by the patient or the guardian. That there is a fee for telephone consultations of greater than 10 minutes. Notice of 24 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of $35. Any special financial arrangements may be made clear in advance.

TO BE COMPLETED BY LEGALLY AUTHORIZED GUARDIAN:

Patient: _____ Legal Guardian:_____

I, _____have read, understood and acknowledge the above statements.

Signature: _____Date: _____