

NATURE'S HEALTH CLINIC & MORE LTD.

Unit # 104, 5020 50A Street, Sylvan Lake, AB T4S 1R2

Phone: (403) 887 - 4425 Fax: (403) 887 - 4463



"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: _____

Personal Information	
Date of Initial Consultation:	
Child's 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:	
Weight: Now:	
One year ago:	
Maximum weight:	
When:	
Height cm/ft	
Siblings:	Siblings:
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
Siblings:	Siblings:
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.

When did you notice your child's problem?

What did you notice?

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

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

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.

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)

NATUROPATH(S)/HOMEOPATH(S)

NUTRITIONIST / OTHER

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

DIETARY / NUTRITIONAL HISTORY

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

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

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

DIETARY / NUTRITIONAL HISTORY (CONTINUED)
PLACE AN X IN THE MOST APPROPRIATE DESCRIPTION BELOW OF YOUR CHILD'S DIET: <input type="checkbox"/> MOSTLY BABY FOOD <input type="checkbox"/> MOSTLY CARBOHYDRATES (BREAD, PASTA, ETC) <input type="checkbox"/> MOSTLY DAIRY (MILK, CHEESE, ETC) <input type="checkbox"/> MOSTLY MEAT <input type="checkbox"/> MOSTLY VEGETARIAN <input type="checkbox"/> 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?	

ENVIRONMENTAL HISTORY

DO YOU, YOUR CHILD, OR ANY FAMILY MEMERS PRACTICE ANY RELAXATION, STRESS MANAGEMENT TECHNIQUES? PLEASE DESCRIBE:

CIRCLE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS AND DESCRIBE:

1.) LOCATION OF HOME: CITY / SUBURBAN / WOODED / FARM / OTHER (DESCRIBE):

2.) WHAT TYPE OF WATER DOES YOUR FAMILY DRINK?

TAP SPRING WELL REVERSED OSMOSIS DISTILLED BRITA FILTERED FRIDGE FILTERED

DO YOU USE LEMON JUICE IN YOUR DRINKING WATER?

3.) TYPE OF HEAT: ELECTRIC / GAS / OIL / OTHER (DESCRIBE):

4.) DO YOU LIVE NEAR: POWER LINES / WOODS / INDUSTRIAL AREA / WATER

5.) IF YOU LIVE NEAR WATER, WHAT TYPE? SWAMP / RIVER / OCEAN / OTHER (DESCRIBE)

6.) DOES YOUR HOME HAVE A LOT OF: DUST / MOLD / DOWN / OR FEATHER ITEMS? IF SO PLEASE DESCRIBE?

DESCRIBE YOUR CHILD'S BEDROOM:

BEDDING: SYNTHETIC / DOWN / FEATHER MATTRESS ENCLOSED: YES/NO CRIB/JR. BED / ADULT BED

FLOORING: CARPET: WALL-TO-WALL AREA RUG WOOD GLUED DOWN SYNTHETIC PAD

WINDOW TREATMENTS: SHADES BLINDS THIN CURTAINS HEAVY CURTAINS VALANCE OTHER(DESCRIBE):

OTHER ITEMS IN ROOM INCLUDING FURNITURE, TOYS, STUFFED ANIMALS, ETC.:

FLOORING IN OTHER ROOMS:

CHILD'S BATHROOM:

LIVING ROOM?

FAMILY ROOM/PLAY ROOM?

IS YOUR CHILD SENSITIVE TO OR BOTHERED BY THE FOLLOWING?

PERFUMES/COSMETICS?	MOLD?	PLEASE LIST ANY OTHER KNOWN ALLERGIES:
CLEANING PRODUCTS?		
POLLENS/GRASSES?		
SOAPS?	ANIMALS (DANDER)	
DETERGENTS?	GASOLINE?	
DUST?	PAINT?	
OTHER?		

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:

2.) PHRASES OR SENTENCE:

3.) SITTING UP:

4.) CRAWLING:

5.) PULLING UP TO A STAND:

6.) WALKING:

7.) RUNNING:

8.) WALKING UP AND DOWN STEPS WITHOUT HELP:

9.) JUMPING:

10.) PUT ON CLOTHING

11.) LEARNED TO PEDAL:

12.) RODE 2-WHEELED BICYCLE:

YOUR CHILD'S MEDICAL HISTORY		
PREVIOUS DIAGNOSTIC STUDIES – PLEASE LIST DATES AND RESULTS:		
PREVIOUS STUDY	DATE(S)	RESULTS
PHYSICAL EXAM		
X-RAYS		
Chest		
Stomach or colon		
Gall bladder		
Extremities		
Back		
Teeth		
HEARING TESTS		
EEG		
EKG		
CT SCAN (BRAIN)		
CT SCAN (OTHER)		
MRI		
LAB WORK		
ATTACH RESULTS IF AVAILABLE		
ANY ABNORMAL RESULTS		
OTHER:		
OTHER:		
OTHER:		

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

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

MAJOR INJURIES – PLEASE DESCRIBE AND GIVE DATES:		
INJURY	DATE(S)	RESULTS

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:		

(Your 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.

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

OTHERS			
NAME	DOSAGE	PURPOSE	RESULTS

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

MEDICAL/THERAPY	TIME WHEN TAKEN	EFFECT

YOUR CHILD'S SIGNS AND SYMPTOMS					
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					

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

Has your child ever had? Continued.			
Please check yes or no.	YES	NO	OTHER COMMENTS
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			
INJURIES: have you had any?			
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? 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			

Has your child ever had? Continued.			
Please check yes or no.	YES	NO	OTHER COMMENTS
Enlarged glands			
Recurrent sore throats			
Recurrent mouth sores			
Soreness or bleeding of gums during brushing.			

Has your child ever had in the last year? Please check yes or no.			
PROBLEM	YES	NO	OTHER COMMENTS
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			

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

Has your child ever had in the last year? Please check yes or no. Continued.			
PROBLEM	YES	NO	OTHER COMMENTS
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			

Your Child's SIGNS AND SYMPTOMS
DESCRIBE ANY OTHER SYMPTOMS YOU WOULD LIKE ME TO KNOW ABOUT YOUR CHILD:
LIST ANY OTHER HISTORY, PERTINENT THOUGHTS OR QUESTIONS THAT YOU WANT TO ADDRESS:

NUMBER OF COMMON PROBLEMS THAT CHILDREN HAVE.					
MARK AN X IN THE RATE ACCORDING TO THE LAST MONTH:					
0-NONE 1&2- IN BETWEEN 3-FREQUENTLY					
	PROBLEM	0	1	2	3
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	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)				

	PROBLEM	0	1	2	3
72	FEELS INFERIOR TO OTHERS				
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				

	PROBLEM	0	1	2	3
77	MOOD CHANGES QUICKLY AND DRASTICALLY				
78	EASILY FRUSTRATED IN EFFORTS				
79	EASILY DISTRACTED BY EXTRANEIOUS STIMULI				
80	BLURTS OUT ANSWERS TO QUESTIONS BEFORE THE QUESTIONS HAVE BEEN COMPLETED				

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

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 Nature's Health Clinic 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.

SIGNATURE PATIENT/RESPONSIBLE PARTY

DATE (m/d/y)