DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

Dear New Patient,

Welcome to the world of Naturopathic Medicine! Deciding to put your health, and YOU, as a priority takes courage. We will now embark on the journey towards optimizing your wellbeing.

If you are unfamiliar with Naturopathic Medicine, the goal is to understand the individual and the cause of his/her ailments so that the root of the concern/condition can be treated to improve his/her overall level of health and wellbeing. Regardless of your familiarity with Naturopathic Medicine, you have decided to incorporate its practices in your global health strategy and I invite all of my patients, current and future, to ask questions – it's your health!

The work we do together will be entirely collaborative and I will do my utmost to help you achieve your goals. I am here as a facilitator in your health and wellness, but of course, you will have to do some work.

I am so thrilled to go on this journey with you and look forward to learning from you and with you.

Please do not be alarmed by the large document you are about to fill out. I know there seem to be a lot of questions to answer, but please do take the time to answer each section carefully as it will only better assist me in understanding where you have been and where you would like to go and to ensure the most effective use of your visit time.

In health,

Dr. Colleen Hartwick ND

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Patient Name: _____
Age: _____ Date of birth: _____
Number of siblings? _____ Birth order: _____
Address: _____
City: _____ Postal Code: _____
Telephone: _____
Guardian name(s): _____
Email: _____
Parents' relationship (circle one): Married Separated Divorced Common Law
Child lives with: _____

Emergency Contact:
Name: _____
Relationship: _____ Tel.: _____

Family Doctor/Pediatrician:
Name _____ Tel. _____

CURRENT HEALTH CONCERNS

What concern(s) brought you to the clinic today? (please list in order of importance)
1. _____
2. _____
3. _____
4. _____
5. _____

When did the concern(s) first begin?_____
_____
_____

Has/have the reason(s) you came to the clinic changed? Gotten better? Worse?
_____
_____
_____
_____

Have you seen any other doctors/practitioners to address your complaint(s)? Which ones?
_____
_____

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What treatments have been tried to address the child's main health concerns?

What was/were the result(s) of these treatment(s)?

What factor(s) do you think are contributing to the primary concern(s)?

How would you characterize your child's personality/temperament?

Have there been any major stressors/traumas in the child's life? Please explain

Is/are the trauma(s) continuing to affect the child? How so?

What is the emotional climate of the child's home?

Is there a history of sexual or domestic abuse? Y / N

Is/are there any illness(es)/trauma(s) from which the child has never been well since?

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PERSONAL HEALTH HISTORY

Please list the dates of any hospitalizations, surgeries or medical procedures (including X-rays, MRI, Bone density scans, EKC, EEG, CT scans, PET scans):

_____

_____

Has the child ever been to the emergency room? Y / N

Why? _____

Does the child have any allergies or sensitivities to any of the following: (please list)
Foods? _____
Medications? _____
Chemicals? _____
Environmental/Airborne? _____

Current Medications: Please list any current medications the child is taking, prescribed or over the counter (OTC).

Medication Name	Dosage	Reason Prescribed	Effect(s)

Previous Medications: Please indicate what medications (prescribed or OTC) the child has taken in the past.

Medication Name	Dosage	Reason Prescribed	Effect(s)

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Supplements: Please indicate which supplements/vitamins the child is CURRENTLY taking Supplement Brand Dosage Reason for taking

Supplement Name	Dosage	Reason Prescribed	Effect(s)

CURRENT HEALTH HABITS

Height _____ Weight: _____

Physical activity: type(s) _____
Frequency (days/week) _____ Duration (mins) _____

Sleep:
Hours/night _____
Does the child sleep well? Y / N Awake and alert? Y / N
Nightmares? Y / N Night terrors? Y / N Sleep walking? Y / N
Regular naps? Y / N Bed Wetting? Y / N Night sweats? Y / N

Interests/Hobbies
Main interests: _____
Does the child play video games? Y/N How often(hrs/day)?_____
Does the child enjoy school? Y / N Plays well with others? Y / N
Does the child watch T.V.? Y / N How many hours/day? _____

Dietary Habits
Breakfast: _____
Lunch: _____
Dinner: _____
Snack(s): _____
Desserts/Sweets: _____
Water (cups/day): _____ Juice (cups/day): _____
Dairy milk (cups/day): _____ Non-dairy milk (cups/day): _____
How often does the child eat out? _____ Has the child been on a diet? Y / N
Any foods the child craves? _____
What is/are the child's favourite food(s)? _____
Any foods the child will NOT eat? _____
Is the child's appetite (check one): Poor _____ Fair _____ Good _____
Does the child frequently consume?
Artificial sweeteners (aspartame, sucralose) Y / N
Artificial colours? Y / N
MSG? Y/N

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Toxin Exposure
Has the child ever lived near a factory or other polluted area? _____
Has the child ever lived in a house with lead paint? _____
Has the child ever live in a house with new paint, cabinets, carpeting installed and did this affect his/her health in any way? _____
Is the child exposed to second-hand smoke? Y / N
Are pesticides or herbicides used in/around your home? Y / N
Is the child particularly sensitive to perfumes or fragrances? Y / N

Childhood Illnesses Please indicate (check) if the child has experienced any of the following:

Measles ____ Mumps ____ German Measles/Rubella _____

Whooping Cough _____ Chicken pox _____

Immunization History

Vaccine	Age	Adverse Reaction(s)?
MMR		
DTaP-IPV-HiB		
Varicella/Chickenpox		
Hepatitis A		
Hib		
Influenza		
HPV		
Rotavirus		
Tdap-IPV		
Pneumococcal		
Meningococcal		

Family History:

Does the child have a family history of any of the following? (check all that apply)

Tuberculosis ____	Cardiovascular disease ____	Diabetes _____
Heart murmurs _____	Anemia _____	Epilepsy _____
Asthma _____	Allergies/Hay fever ___	Obesity _____
Depression _____	Anxiety _____	Cancer _____
Celiac disease _____	Autoimmunity _____	Other? _____

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REVIEW OF SYSTEMS

Please indicate if any of these are a Past (P) or Current (C) issue (circle)

MENTAL			**EMOTIONAL**		
Speech impediments	C	P	Hyperactivity	C	P
Inattention	C	P	Fears/phobias	C	P
Developmental disability	C	P	Excessive disobedience	C	P
Learning impediments	C	P	Temper tantrums	C	P
NEUROLOGIC			**IMMUNE**		
Seizures	C	P	Frequent colds/flu	C	P
Dizzy spells/fainting	C	P	Slow wound healing	C	P
Muscle weakness	C	P	Swollen glands	C	P
Paralysis	C	P	Tonsillitis	C	P
ENDOCRINE			**SKIN**		
Diabetes (insulin-dependent)	C	P	Warts	C	P
Excessive thirst	C	P	Cradle Cap	C	P
Excessive hunger	C	P	Eczema	C	P
Other? _____	C	P	Psoriasis	C	P
			Diaper rash	C	P
HEAD			Hives	C	P
Headaches	C	P			
Migraines	C	P	**NOSE and SINUSES**		
Head injury/Concussion	C	P	Stuffiness	C	P
Meningitis	C	P	Nasal drip	C	P
			Nose bleeds	C	P
EYES			Allergies	C	P
Impaired vision	C	P			
Blindness	C	P	**MOUTH and THROAT**		
			Cavities	C	P
			Strep throat	C	P
RESPIRATORY			**NECK**		
Bronchitis	C	P	Pain/Stiffness	C	P
Pneumonia	C	P	Goiter	C	P
Asthma	C	P	Swollen Glands	C	P
Cystic Fibrosis	C	P			
			BLOOD		
CARDIOVASCULAR			Anemia	C	P
Heart murmur	C	P	Easy Bruising	C	P
High blood pressure	C	P	Leukemia	C	P

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URINARY			**MUSCULOSKELETAL**		
Frequent urination	C	P	Growing pains	C	P
Blood in urine	C	P	Scoliosis	C	P
Pain with urination	C	P	Joint pain	C	P
Bedwetting	C	P	Bone pain	C	P
GASTROINTESTINAL			**MALE**		
Jaundice as a newborn	C	P	Early puberty	C	P
Colic	C	P	Undescended testicle	C	P
Diarrhea	C	P	Testicular torsion	C	P
Constipation	C	P			
Stomachache/pain	C	P	**FEMALE**		
Appendicitis	C	P	Early puberty	C	P
Gas/bloating	C	P	Menstrual cramps/PMS	C	P
Belching	C	P	Breast tenderness	C	P
Intestinal worms	C	P	Age of first menses? _____		

MOTHER'S PREGNANCY

Check one: Full Team? ___ Premature? ___ Late? ___
Any prenatal care? Y / N
Please describe: _____
Were prenatal vitamins used? Y / N
Which ones? _____
Any illnesses during pregnancy? Y / N
Which ones? _____
Nausea/vomiting? Y / N
Major stressors? _____
Smoking? Y / N how much? _____
Coffee/Caffeine(cups/day)? _____
Recreational drugs? Y / N
Prescription drugs? Y / N
Diabetes? Y / N
Hypertension/High blood pressure? Y / N
Thyroid problems? Y / N
During pregnancy was the mother exposed to any of the following?
Rubella __ Herpes ___ Chicken pox __ Cytomegalovirus __ Toxoplasmosis __
Length of labour: _____ Was labour induced? Y / N
Vaginal birth? Y / N Epidural/Anesthesia? Y / N Forceps? Y / N C-section?Y/N Vacuum extraction? Y/N
Any difficulties during labour? _____
Did the child experience any of the following shortly after birth? (check all that apply)
Infection/Fever? __ Trauma? __ Seizures? __ Jaundice? __
Respiratory Distress? __ Rashes? __ Anemia? __ Birth defects? __ Was the child breastfed? Y / N For how long? _____

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Was formula used? Y / N Which kind? _____
When did you introduce solid foods? _____
At what age did the child first start crawling? _____
Sit up? _____
First walk? _____
First talk? _____
First develop baby teeth? _____ Adult teeth? _____

Is there anything else you want to add? _____
_____
_____

Thank you for your time in completing this form.

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