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Profile Information — Step 1 of 3

You are completing the intake form: **Children's Health Questionnaire** for **

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.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Preferred Name (if different)

Prefix / Title

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone

CA

A mobile phone is required if you would like to receive SMS appointment reminders.

Home Phone

CA

Country

Canada

Street Address

Suite Number (i.e. Suite #100)

City

Province

Postal / Zip

Date of Birth

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

How did you hear about us?

How did you hear about us?

Who were you referred to?

Matrix Health Solutions

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Questionnaires — Step 2 of 3

You are completing the following intake forms: Children's Health Questionnaire

Children's Health Questionnaire

Dear Parents/Guardians:

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 overall health status and to advise you on measures to ensure optimal well-being. During the course of you examination and treatments, please feel free to comment, ask questions, and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health. Together, we can form a team on the side of a healthy future.
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. Please print.

Thank you.

What is your chief concern about your child's health – *Required*

What else would you like to see changed in their health? – *Required*

If there is a specific condition, how long has it been occurring? List any practitioners seen for this reason. – *Required*

List diagnoses, types of treatment, medications, etc. – *Required*

Is there a relative with similar problems? If yes, please provide details: – *Required*

- [ ] 1. Yes
- [ ] 2. No

List any medications your child is presently taking, and doses. – *Required*

Has your child had any x-rays taken in the last three years? Please list areas: – *Required*

☐ 1. Yes

☐ 2. No

Has your child lost any days at school recently? If Yes, please list dates – *Required*

☐ 1. Yes

☐ 2. No

What do you feel is causing your child's health problems? – *Required*

When was your child last well? – *Required*

Does your child have regular sleep habits? If no, list how many hours – *Required*

☐ 1. Yes

☐ 2. No

Early riser? – *Required*

☐ 1 .Yes ☐ 2. No

Difficulty falling asleep? – *Required*

☐ 1. Yes ☐ 2. No

Nightmares/Night terrors? – *Required*

☐ 1. Yes ☐ 2. No

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

Vaccination – *Required*

Age – *Required*

Adverse Reactions – *Required*

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

Please indicate age and if it was mild, average or severe – *Required*

☐ 1. Roseola

☐ 2. Rubella/German Measles

☐ 3. Rubella/Measles

☐ 4. Chicken Pox

☐ 5. Mumps

- [ ] 6. Scarlet Fever
- [ ] 7. Pertussis/Whopping Cough
- [ ] 8. Strep Throat
- [ ] 9. Impetigo
- [ ] 10. Mononucleosis
- [ ] 11. None of the above

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

Surgery – *Required*

Hospitalization – *Required*

Accidents – *Required*

Major Illnesses – *Required*

Loss of Consciousness – *Required*

Seizures – *Required*

Is there a history of any of the following in your family? (Please circle and state relationship of family member): – *Required*

- [ ] 1. Alcoholism
- [ ] 2. Allergies
- [ ] 3. Arteriosclerosis
- [ ] 4. Arthritis
- [ ] 5. Asthma
- [ ] 6. Bed Wetting
- [ ] 7, Candida Albicans

- [ ] 8. Cancer
- [ ] 9. Cataracts
- [ ] 10. Celiac
- [ ] 11. Colitis
- [ ] 12. Depression
- [ ] 13. Diabetes
- [ ] 14. Epilepsy
- [ ] 15. Heart Disease
- [ ] 16. Hyperactivity
- [ ] 17. Kidney Disease
- [ ] 18. Learning Disability
- [ ] 19. Mental Disease
- [ ] 20. Muscular Dystrophy

☐ 21. Multiple Sclerosis

☐ 22. Schizophrenia

☐ 23. Stomach ulcers

☐ 24. Stroke

☐ 25. Tuberculosis

☐ 26. Yeast Infections

☐ 27. Venereal Disease

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

1. Poor 2. Fair 3. Good 4. Excellent

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

1. Poor 2. Fair 3. Good 4. Excellent

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

1. Poor 2. Fair 3. Good 4. Excellent

Comments – *Required*

What supplements/vitamins was the mother taking during the pregnancy? – *Required*

What medications did the mother take during the pregnancy? Prescription and/or Over the counter – *Required*

Did the mother smoke before the pregnancy? If yes, how many cigarettes per day? – *Required*

☐ 1. Yes

☐ 2. No

Did the mother smoke during the pregnancy? If yes, how many cigarettes per day? – *Required*

☐ 1. Yes

☐ 2. No

Does anyone in the household currently smoke? – *Required*

☐ 1. Yes ☐ 2. No

Did the mother drink alcohol during the pregnancy? If yes, indicate beverage, amount and frequency: – *Required*

☐ 1. Yes

☐ 2. No

The mother's diet during the pregnancy was:

1. Poor 2. Fair 3. Good 4. Excellent

What was the mother's emotional state during pregnancy?

1. Excellent 2. Stable 3. Stressed 4. Very Stressed

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

1. Excellent 2. Stable 3. Stressed 4. Very Stressed

How was the birth of the child? Indicate if there was a Caesarian section, forceps, or any complications: – *Required*

Has your child had colic? – *Required*

☐ 1. Yes ☐ 2. No

Was your child breast-fed? If yes, for how long? If no, what formula were they given? – *Required*

☐ 1. Yes

☐ 2. No

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

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

List child's favorite foods – *Required*

Please list what is a typical: – *Required*

- [ ] 1. Breakfast

- [ ] 2. Lunch

- [ ] 3. Supper

Your child's appetite is:

1. Poor | 2. Fair | 3. Good | 4. Excellent

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

What are your observations about your child's temperament? – *Required*

Is your child's physical development:

1. Slower than average | 2. Average | 3. Faster than Average

Is your child's mental/emotional development:

1. Slower than average | 2. Average | 3. Faster than average

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

What form of heating do you have presently? – *Required*

☐ 1. Oil ☐ 2. Electric ☐ 3. Gas

Are there any pets in the household? If yes, what kind? – *Required*

☐ 1. Yes

☐ 2. No

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Consents — Step 3 of 3

You are completing the following intake forms: Children's Health Questionnaire

Email Communication

News and Special Promotions

☐ Yes, I would like to receive news and information by email

Children's Health Questionnaire — Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree – *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

☐ I am aware of the Cancellation Policy. – *Required*

Please check that all required questions have been answered.

Submit Intake Form