Dr. Keith Condliffe, B.A., ND
220 - 1529 West 6th Ave.
Vancouver, BC V6J 1R1

Consent to the Treatment of a Minor

I, _____ do hereby authorize Keith Condliffe, N.D.,
(Parent or Guardian's Name)

Naturopathic Physician at the Awen Health Centre, to examine and administer Integrative Medical care to

my _____ (Indicate Relationship)

_____
(Name of Child)

Signed in Vancouver, in the province of British Columbia, Canada, this _____ day of _____, 20_____.

Signature of Parent or Legal Guardian: _____

Witness: _____

AWEN health centre

Dr. Keith Condliffe, B.A., ND
220 - 1529 West 6th Ave.
Vancouver, BC V6J 1R1

Thank you for taking the time to fill out this form. The information is very important in the assessment of your case

Child's Name: _____ Parent's Name: _____ Date: _____
Sex: _____ Age: _____ Date of Birth: _____ Birthplace: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Email: _____ Phone: (____)_____ H / C Phone: (____)_____ H/ W/ C
Referred by: _____ Parent's marital status: _____
Family Physician: _____ Phone: (____)_____

What are the child's main health concerns?

_____
_____
_____
_____

Medical History - General

Date of last physical exam: _____
Weight: _____ Height: _____
Hours of sleep/night: _____
Number of times wake up during the night: _____

Vaccinations (please check)

❑ DTap / IPV / HiB (Diptheria, Tetanus, Pertussis, Polio, Haemophilus Influenza type b) Vaccine
❑ Hepatitis B Vaccine
❑ MMR (Measles Mumps Rubella) Vaccine
❑ Men-C (Meningococcal C Conjugate) Vaccine
❑ Chicken Pox (Varicella) Vaccine
❑ DTap / IPV Booster (4-6 years old)
❑ HPV (Human Papillomavirus) Vaccine

Other: _____
Did the child have a reaction to any of these vaccinations? (e.g. fever?) ❑ Yes ❑ No
If yes, what type of reaction? _____
_____

Dental

Any Dental Fillings? ❑ Yes ❑ No
How many? _____ When? _____
What type? _____

Please circle "Y" if your child has the condition now and "P" if they had it in the past.

Jaundice	Y	P
Sleeping problems	Y	P
Eczema / Rashes	Y	P
Ear infections	Y	P
Cries a lot	Y	P
Difficult to please	Y	P
Lack of energy	Y	P
Tantrums	Y	P
Hyperactivity	Y	P
Convulsions	Y	P
Learning problems	Y	P
"Problem Child"	Y	P
Nervous Child	Y	P
Bedwetting	Y	P
Breathing problems	Y	P
Asthma	Y	P
Heart Murmur	Y	P
Hearing problems	Y	P
Vision problems	Y	P
Speech problems	Y	P
Teeth problems	Y	P
Colic	Y	P
Constipation	Y	P
Digestive upsets	Y	P

Bowel movements per day: _____
Colour: _____
Other: _____

Childhood Diseases:

Frequent colds	Y	P
Chicken Pox	Y	P
Whooping cough	Y	P
Measles / German Measles	Y	P
Diptheria	Y	P
Accidents	Y	P
Injuries / Burns	Y	P

Operations: _____

Hospitalizations: _____

Other: _____

_____

Birth History:

Weight at Birth: _____

Rh Blood Problem? ❑ Yes ❑ No

Any birth complications (during or after delivery)?

_____

_____

Delivery: ❑ Vaginal ❑ Caesarian ❑ Premature

Forceps aided: ❑ Yes ❑ No

Where? ❑ Home ❑ Hospital

Difficult? ❑ Yes ❑ No

No. of hours of labour: _____

Drug aided? ❑ Yes ❑ No

If yes, what drugs: _____

_____

_____

Feeding:

Breast? ❑ Yes ❑ No

How many months? _____

Bottle? ❑ Yes ❑ No

Type of milk? _____

Solid foods started at _____ months

What food was introduced first? _____

_____

Mother's Pregnancy History:

Difficulty in becoming pregnant? ❑ Yes ❑ No

If yes, what? _____

_____

Was the pregnancy stressful for you? ❑ Yes ❑ No

Did you have any of the following?

❑ Nausea
❑ Vomiting
❑ Anemia
❑ Shocks / Trauma
❑ Hospitalizations
❑ Extreme Tiredness

Mother's Pregnancy History (Con't):

Were any of the following used during pregnancy?

❑ Cigarettes ❑ Alcohol

❑ Recreational Drugs If yes, what?_____

_____

❑ X-Rays ❑ Ultrasound

❑ Sedatives ❑ Sleeping Pills

❑ Antibiotics ❑ Iron Supplements

Were you on a special diet? ❑ Yes ❑ No

How many lbs. / kgs did you gain? _____

If your child is between the ages of 6 and 12, please have them complete the following questions:

Please check if you feel (most days):

❑ Nervous ❑ Unhappy

❑ Hyperactive ❑ Need to sleep a lot

❑ Lazy ❑ Irritable

❑ Discontent ❑ I'm a slow learner

❑ I'm accident prone

Do you...

Have many fears? ❑ Yes ❑ No

Lack confidence? ❑ Yes ❑ No

Feel you are different? ❑ Yes ❑ No

Prefer to be alone? ❑ Yes ❑ No

Prefer to be with friends? ❑ Yes ❑ No

Prefer to be with family? ❑ Yes ❑ No

Get angry easily? ❑ Yes ❑ No

Have sleeping problems? ❑ Yes ❑ No

Bite nails? ❑ Yes ❑ No

Grind teeth? ❑ Yes ❑ No

Wet the bed? ❑ Yes ❑ No

Difficulty concentrating? ❑ Yes ❑ No

Are your eyes sensitive to light? ❑ Yes ❑ No

How often do you miss school because of illness?

_____

Do you get along with the rest of the family?

❑ Yes ❑ No

On a scale of 1-10 (10=very happy), how happy are you with your life? _____

If you could change something in your life what would it be? _____

_____

_____

What do you worry about? _____

_____

_____

_____

_____