AWEN
health centre

Dr. Keith Condliffe, B.A., N.D.
1819 Beaufort Ave., Unit 102
Comox, BC V9M 1R9
1 (888) 675-8344

Welcome to the Awen Health Centre. We look forward to working with you.

Please either:
1) print and complete this document (4 pages) and bring it with you to your first visit, or
2) electronically fill, digitally sign, and email this document to *clinic@awenhealth.ca*.

Please initial or check (if filling it out digitally) your agreement in each box below:

☐ I have read, understand and accept the Working Together at Awen document, including the 48 hour cancellation policy and the fee schedule. I agree to pay my account in full after every visit, unless other arrangements have been made prior to my visit.

☐ I consent to my child's clinic health file and medical records being stored in a secure, password-encrypted electronic format, backed up to a secure, password-encrypted server service in Canada.

☐ I consent to being added to the client email list (optional and recommended). Clinic-related announcements may be sent out to this list (average once or twice per year). I can unsubscribe from this list at any time.

☐ I consent to clinic and health-related email correspondence between my email address and a clinic email address (optional and recommended). This may include digital copies of program suggestions, receipts, and / or answers to health-related questions that I initiate.

☐ I have read and signed the consent form, and completed the questionnaire as fully and honestly as possible.

☐ I accept responsibility for my child's health. This includes informing Dr. Keith if the program does not suit our needs or expectations.

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Consent to the Treatment of a Minor

I, _____
(parent or guardian's name)

_____ of _____
(Indicate Relationship) (Name of Child)

acknowledge and declare that I have the option of seeking/continuing allopathic (conventional) medical care from a medical doctor for my child and that the naturopathic medical treatments at this clinic and allopathic medical treatments are different but not mutually exclusive. I confirm that there has been no suggestion made to me by Keith Condliffe, The Awen Health Centre, or anyone under its direction or control, that I refrain from seeking or following conventional medical treatment for my child.

I also understand that the Naturopathic Physician at The Awen Health Centre is trained to read and interpret x-rays, ultrasounds, and other conventional medical tests but is (currently) restricted from ordering several of these tests in the Province of British Columbia. Therefore, it is my responsibility to maintain contact with a Medical Doctor so that all necessary testing may be performed as required to monitor my child's condition. Furthermore, I realize that the Naturopathic Physician at this clinic may use testing procedures that are not conventional to assess the progress of therapy, and are by no means tools to accurately diagnose a disease.

I understand that the Naturopathic Physician at the Awen Health Centre does not treat the symptoms of disease; rather he will help me assess and correct the imbalances in my child's body, nutrition and lifestyle so that they can begin and / or continue to heal themselves.

I understand that all information given to the Awen Health Centre is guarded in strict confidence at all times, subject to doctor-patient confidentiality laws. I also acknowledge that for the purposes of teaching other healthcare practitioners, broad information about my child's case may be reviewed in a classroom context, with absolutely no identifying information disclosed at any time.

On reading and understanding the above, I hereby authorize Keith Condliffe, N.D., Naturopathic Physician at the Awen Health Centre, to assess and treat my child as named above.

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

Signature of Parent or Legal Guardian: _____

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

Child's Name: _____ Parent's Name: _____

Date of Birth: _____ Birthplace: _____ Sex: _____ Age: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Email: _____ Phone (cell) : (____)_____ Phone (alt): (____)_____

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

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

Bowel movements per day:_____

Colour: _____

Other: _____

Childhood Diseases: **Y** **P**

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

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 ☐ Shocks / Trauma
☐ Vomiting ☐ Hospitalizations
☐ Anemia ☐ 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 your 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?_____
_____
_____