Maria Gyuro, B.Sc., D.N.M., R.h.A.
Doctorate of Natural Medicine, Registered Holistic Allergist
Complete Wellness Clinic, 235 Starwood Drive, Unit 3, Guelph, ON N1E 7E8
519-763-8855

# CONSENT TO TREATMENT OF A MINOR

***PATIENT INFO:***

FULL NAME: ______________________________________________

AGE: __________ DATE OF BIRTH:______________________________

GENDER: _________

ADDRESS: ______________________________________________

CITY: ______________________PROV:__________POSTAL CODE:_____________

I ( parent / guardian ),____________________________________________
give my consent for the above Doctor of Natural Medicine to examine and administer Natural Medicine care and treatment to ______________________________
whose relationship to me is as a ___________________________________.

I have been given an explanation of and understand the nature of the Natural Medicine care and treatment. I authorize the above Doctor of Natural Medicine to take whatever measures she considers necessary or desirable in connection with such natural medical care and treatment.

***CONTACT ( PARENT / GUARDIAN ) INFO:***

FULL NAME: ______________________________________________

ADDRESS ( if different from child's):_______________________________

CITY: ______________________PROV:__________POSTAL CODE:_____________

PHONE (HOME): ________________________(WORK):________________________

CELL PHONE: ______________________________________________

DATED at Guelph, in the Province of Ontario, this _______ day of __________ , ______
( month ) ( year )

____________________________________ ________________________________
**Parent or Guardian of Minor – print name** **Signature**

____________________________________ ________________________________
**Witness – print name** **Signature**

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***CHILD PATIENT INTAKE QUESTIONNAIRE***

Date: ________________________________
Child's Name: _______________________________________ Age:_____________
Birthdate (Day-Month-Year):______________________________ Gender: M F
Mother's Name:______________________Father'sName:_____________________
Child was 1st 2nd 3rd 4th 5th 6th born in a total of _________ siblings.

Child's other health care providers: ( Please list name, phone number )
1.____________________________________________________________________
3.____________________________________________________________________

What are your child's main health concerns. In order of importance:
1.____________________________________________________________________
2.____________________________________________________________________
3.____________________________________________________________________
4.____________________________________________________________________
5.____________________________________________________________________

**Medical History**
How would you describe your child's general state of health? Poor Fair Good Excellent

Please indicate any serious conditions, illnesses or injuries, any hospitalizations, surgeries, along with approximate dates:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Which of the following has your child had? n-never m-mild a-average s-severe

| | | | |
|---|---|---|---|
| n m a s | rubella (German measles) | n m a s | roseola |
| n m a s | measles | n m a s | scarlet fever |
| n m a s | chicken pox | n m a s | whooping cough |
| n m a s | mumps | n m a s | strep throat |
| n m a s | impetigo | n m a s | mononucleosis |
| n m a s | ear infections | | |

Does your child have any allergies ( foods, animals, environmental, medications, etc.)

Please list all current medications ( prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

How many times has your child been treated with antibiotics? ____________________

Please indicate what immunizations your child has had:

| DPT (Diptheria, Pertussis, Tetanus) | "Flu" |
|---|---|
| MMR (Measles, Mumps, Rubella) | Polio |
| Tetanus booster, when? | Hepatitis A |
| Haemophilus influenza B | Hepatitis B |
| other: | |

Please indicate if any caused adverse reactions and what they were:

Please list any screening tests your child has had ( blood, hearing, vision, etc ):

**Family History**

Please indicate/circle if there is any history of the following conditions in the family and give details: OR ( ) I don't know the family medical history

| Allergies | Birth defects | Heart disease | Kidney disease |
|---|---|---|---|
| Arthritis | Cancer | Hypertension | Psoriasis |
| Asthma | Diabetes | Mental illness | Tuberculosis |
| Multiple Sclerosis | Eczema | Auto-immune disorders | |

Other:____________________________________________________________

Do either of the parent's have a chronic illness? **Y N** Please describe:

**Prenatal Health**

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown ________________________

Father: Poor Fair Good Excellent Unknown ________________________

What was the mother's age at child's birth? ________ Father's? _______
Mother's health during pregnancy? Any complications?

______________________________________________________________________
______________________________________________________________________

Mother's diet during Pregnancy?____________________________________________
Was this pregnancy planned?______________________________________________
Number of previous pregnancies, miscarriages, or complications:

______________________________________________________________________
______________________________________________________________________

Did the mother experience any of the following during the pregnancy
( ) Bleeding ( ) High blood pressure ( ) Nausea ( )Vomiting
( ) Diabetes ( ) Thyroid problems ( ) Physical or emotional trauma
( ) other: _______________________________________________________

Did the mother use any of the following during the pregnancy?
( ) Tobacco ( ) Alcohol ( ) Recreational drugs ___________________
( ) Prescription medications: ______________________________________
( ) Over-the-counter medications: __________________________________
( ) Supplements: ________________________________________________
( ) other: _______________________________________________________

Was the birth: Vaginal C-section Induced Forceps Anesthesia used
Term length: ( ) Full ( ) Premature: __________weeks ( ) Late: __________weeks
Length of labour: ________________________Weight at birth: ______________
Any complications to mother: __________________________________________

Has the child had any of the following at or shortly after birth:
( ) Jaundice ( ) Colic ( ) Blue baby ( ) Rashes ( ) Seizures
( ) Birth injuries: ______________________________________________
( )Birth defects: _______________________________________________

Was the child breast fed? **Y** **N** For how long? ___________________________
If not, then Formula: Milk / Soy / Rice based : _____________________________
Other: _____________________________________________________________

What foods were introduced before 6 months?
( Please list approximate month as well )

______________________________________________________________________
______________________________________________________________________

at 6 – 12 months?

______________________________________________________________________
______________________________________________________________________

Does your child have any dietary restrictions ( religious, vegetarian / vegan, etc. )?

Describe a typical day's diet:
Breakfast
Lunch
Dinner
Snacks

Beverages (and total quantity)

Describe your child's sleep pattern :
How would you describe your child's temperament?

**Environment**

How would you describe your child's behaviour and performance at school?

How would you describe your child's behaviour at home?

What are the child's favourite activities?

Does the child exercise regularly? **Y N** List type, frequency, duration:

Does anyone in the child's household smoke? **Y N**
Do you know of any toxins or other hazards that the child is regularly exposed to?

How would you describe the emotional climate of the child's home?

Is there anything that you feel is important that has not been covered?

***Thank you for answering all of these questions. Your accurate responses are vital for an effective natural medicine treatment. This information is confidential.***