

NAME _____
DATE _____

# Welcome to UR Wellness!

## Child Health Care Inventory

Please take the time to document your child's Health Care History. The information collected will help us assist you to identify any contributing stress factors.

### Your Child's Vital Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

In case of an emergency Please notify: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Parents Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
                  month      day      year

School Grade: \_\_\_\_\_

Parent's names:  
\_\_\_\_\_

Siblings (names and ages):  
\_\_\_\_\_  
\_\_\_\_\_





Was your child subjected to any of the following? Please circle all that apply:

Incubation How long: \_\_\_\_\_ Separation from you How long: \_\_\_\_\_

Hepatitis shot Antibiotic Therapy

Was infant alert and responsive within 12 hours of delivery? Yes No

If no, explain: \_\_\_\_\_

### VACCINATION HISTORY:

Has your child received the medical recommended vaccinations? Yes No

If so, any negative reactions? No Yes if yes, please explain

### DEVELOPMENTAL HISTORY:

#### Physical Traumas

Any falls from couches, beds, change tables? No Yes \_\_\_\_\_

Any hospitalizations or surgeries? No Yes \_\_\_\_\_

History of antibiotics? No Yes \_\_\_\_\_

Do you consider sleeping pattern normal? No Yes \_\_\_\_\_

Central Nervous System Infections? No Yes \_\_\_\_\_

Drug overdosing or poisoning? No Yes \_\_\_\_\_

High fevers? No Yes \_\_\_\_\_

Any Serious Medical Conditions No Yes \_\_\_\_\_

#### Growth and Development

Number of hours of sleep? \_\_\_\_\_ Quality? Good Fair Poor

Night terrors, sleep walking, difficulty sleeping? No Yes \_\_\_\_\_

Was child breast fed? No Yes How long? \_\_\_\_\_

Difficulties with lactation No Yes \_\_\_\_\_

Any problems with bonding? No Yes \_\_\_\_\_

Behaviour problems? No Yes if yes, please explain

\_\_\_\_\_  
\_\_\_\_\_

Was language development: (please circle)

typical slower than normal faster than normal?

\_\_\_\_\_

Was eye hand co-ordination: (please circle)

typical slower than normal faster than normal?

\_\_\_\_\_

Was appetite/digestion: (please circle)

typical less than normal more than normal?

Any food allergies? No Yes \_\_\_\_\_

Any sports played? No Yes \_\_\_\_\_

**Psychological Stress/Life Changes**

Do you feel that your child's social and emotional development is normal for their age?

Yes No if no, please explain

\_\_\_\_\_  
\_\_\_\_\_

Have there been any school changes? No Yes \_\_\_\_\_

Has there been any death in the family? No Yes \_\_\_\_\_

Move/Relocation? No Yes \_\_\_\_\_

Divorce/Remarriage? No Yes \_\_\_\_\_

Family Member(s) with chronic illness? No Yes \_\_\_\_\_

**Current Symptom Check List:** please check all that apply

	✓ Client	✓ Family	✓ Current
Always on the go	_____	_____	_____
Feeling tense	_____	_____	_____
Depressed	_____	_____	_____
School problems	_____	_____	_____
Hyperactivity	_____	_____	_____
Attention problems	_____	_____	_____
Memory problems	_____	_____	_____
Behavioural problems	_____	_____	_____
Difficulty making friends	_____	_____	_____
Vocal or motor tics	_____	_____	_____
Sleep problems	_____	_____	_____
Nightmares	_____	_____	_____
Frequent Illnesses	_____	_____	_____
Shy with people	_____	_____	_____
Oppositional	_____	_____	_____
Headaches	_____	_____	_____
Allergies	_____	_____	_____
Physical/Sexual Abuse	_____	_____	_____
Seizures	_____	_____	_____
Food Sensitivities	_____	_____	_____
Head injury	_____	_____	_____
Temper tantrums	_____	_____	_____
Remorseful after tantrums	_____	_____	_____
Bedwetting	_____	_____	_____
Teeth grinding	_____	_____	_____
Rages	_____	_____	_____
Verbal aggression	_____	_____	_____
Inferiority feelings	_____	_____	_____
Cannot make decisions	_____	_____	_____
Frequent stomachaches	_____	_____	_____
Poor math concepts	_____	_____	_____
Poor spelling concepts	_____	_____	_____
Poor language skills	_____	_____	_____
Rushes through work	_____	_____	_____
Poor visual tracking	_____	_____	_____
Perfectionist	_____	_____	_____
Poor eye contact	_____	_____	_____
Loud un-modulated voice	_____	_____	_____
Generalized anxiety	_____	_____	_____
Misses social cues	_____	_____	_____
Manipulative	_____	_____	_____
Fearful	_____	_____	_____
Lacks empathy	_____	_____	_____
Autistic symptoms	_____	_____	_____

**COMMITMENT TO HEALTH STATEMENT & AUTHORIZATION FOR CARE OF A MINOR (Under Age 16)**

Print Parent Name \_\_\_\_\_

I hereby authorize and consent to the services of Neurofeedback, Craniosacral Therapy and Reflexology for my child \_\_\_\_\_.

I understand that UR Wellness exists to make a positive contribution in the lives of people, by assisting them to express and experience more balance in their lives. UR Wellness' services are not a substitute, an alternative or a preventative form of medicine. It is not the goal or intention of Penny Hyndman to diagnose, treat or attempt to cure any physical, mental, emotional ailments, or to give advice about medical conditions. If, while in our care, you become concerned about symptoms or conditions, we suggest you discuss this with us and we will assist you to seek the help of a professional health care practitioner. UR Wellness services can elicit the relaxation response which has been documented to reduce physical & emotional stress. People who have engaged in UR Wellness' services have reported a reduction of physical and emotional symptoms which can cause you to communicate better with yourself and the outside world. Our primary goal is assist your child to bring balance into their life by assisting them to increase their body awareness, learning self regulation and stress management techniques.

To gain maximum benefit from your sessions with Penny Hyndman, it is recommended that you follow these recommendations:

**#1 Consistency in Visits-** on your first visit, we will discuss frequency and number of sessions to reach maximum progress. We ask that you make a commitment to the health plan by making your visits a top priority. Our services work best with consistent and cumulative care. Your time is reserved for you and missed appointments will be billed for.

**#2 Eat an organic whole foods diet-**this is one of the most important steps you can take to heal all kinds of chronic issues.

**#3 Avoid Sugar and Stimulants** -immediately prior to your visits. This will maximize the benefits.

I \_\_\_\_\_ the undersigned, have completely read and understand the above Commitment to Health Statement.

☞ Signed, \_\_\_\_\_ Dated: \_\_\_\_\_

☞ Witness Signature \_\_\_\_\_ Dated: \_\_\_\_\_

