Dr. Alana Berg
Axiom Health Clinic

Welcome to the office of Dr. Alana Berg, of Axiom Health Clinic! We are honoured that you have chosen us in your search for optimal health. Please fill out and sign the attached forms to the best of your ability, and bring them to the initial appointment. It will aid in your assessment of your present health, and facilitate in your process of healing.

If you wish to cancel or reschedule your appointment; please do so **48 hours** or more before your appointment. We do reserve the right to **charge full cost** of the visit for missed appointments, or if less than 24 hrs is given for cancellations. We will confirm your appointment 2 days prior to your visit by email reminder, please ensure you email is correct. If you are undergoing any treatments, please do not come on an empty stomach, as this may raise some of the risks associated with therapies. If you have any questions, please call our office or speak to the reception staff. We look forward to growing with you!

Note: many of our patient are sensitive to environmental substances; therefore, we ask that all patients refrain from wearing scented hairsprays, colognes, perfumes aftershaves, etc., on the day of your appointment.

Payment Requirements: Appointments must be paid for at the time of service. We accept VISA, MC, Debit, and cash.

Records: We keep a record of your health care services. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to. You can obtain copies of the files for a small fee upon signing an authorization form. Please allow up to 10 working days to process the request.

Insurance: Axiom Health does not directly bill insurance companies. You may submit your paid invoice to your insurance company for reimbursement. We are also not a Government Funded healthcare provider, and no reimbursement will be honoured by this organization.

I understand that I will have asked a Dr. Berg of Axiom Health Clinic for help and that she will help to the best of her ability.

I have read and understand the above statements.

_____	_____	_____
Print Name	Signature (signed by guardian if under-age)	Date

Axiom Health Clinic

Child Intake Form

Date:_____ How did you hear about us?_____

Name:_____ Birth date:(M)___/(D)___/(Y)____
Last First Middle Initial

Personal Health Care Number: _____

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone: Work:_____ Home:_____ Email:_____

Emergency Contact: _____ Number:_____

Who is filling out this form? _____ Relation:_____

Height: _____ Weight:_____

Max weight:_____ When: _____

Please list any Practitioners that you are currently seeing (conventional and/or alternative)

Name:	Number:	How long:

Child's chief concerns in order of importance:	**Onset:**	**Frequency:**	**Severity:**
Example: Headaches	*June '91*	*3 X week*	*Mild/mod/severe*
1.			
2.			
3.			
4.			
5.			

What are the goals for this visit? _____

Have there been given a diagnosis from other practitioners for any of these problems – if so what? _____
_____

Please fill in this form with any medication (prescription and non), vitamin, mineral, amino acid, or other supplements that they may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
Example: Vitamin C	*Natural Factors*	*Tablet*	*500mg*	*3 X day*

Comments: _____

PAST MEDICAL HISTORY:

Hospitalizations: _____
_____
Surgeries (year and type): _____
_____
Serious Illnesses/ Accidents/ Injuries (year, cause, and injury): _____
_____
General anaesthetic used? Y N When? _____
Antibiotic use? Y N When? _____
Allergies (type and onset)? _____
_____
Pets (what kind and how many)? _____
_____
Mother health: Poor Fair Good Excellent
Father health: Poor Fair Good Excellent
Any medical interventions in conception, pregnancy, or labour (medication, artificial insemination, etc.) _____
_____
Birth: Vaginal C-section Induced Forceps Anesthesia used
Birth weight:_____ height:_____ length:_____ head circumference:_____
Breast fed: Y or N how long?_____ Problems associated:_____

Illnesses:

Health as a child: (1) Poor to (10) Excellent _____ Explanation: _____

___ Rheumatic fever	___ German Measles	___ Polio
___Allergies	___ Chicken pox	___ Mumps
___ Asthma	___ Ear infections	___ Skin conditions

Vaccinations: (please check all that apply)

( ) DPTP (Diphtheria, Pertussis, Tetanus, Polio) ( ) Meningococcal
( ) Booster (usually DT) ( ) Pneumococcal
( ) Chicken pox ( ) H. Influenza B
( ) MMR (Measles, Mumps, Rubella) ( ) HPV
( ) HBV (Hepatitis B Vaccine) ( ) Shingles
( ) Other (flu shot, etc)

Family History:

Has anyone in their immediate family had any of the following:

___Cancer ___High blood pressure ___Diabetes
___Heart Disease ___Allergies ___Arthritis
___Epilepsy ___Glaucoma ___Mental Illness
___Alcoholism ___Stroke ___Obesity
Other _____

School:

School Name:_____ Grade:_____
Favourite Subject:_____ Least Favourite:_____
Do you enjoy school: Y / N Attention Span: long / short / bored easily
Do you find school difficult: Y / N Challenging: Y / N

Lifestyle:

24 Hour Diet Recall:
Breakfast: _____Lunch: ____
_____
Dinner: _____
Snacks: _____Beverages:_____
Daily Water intake:_____Foods Avoided:_____
Do they exercise or play sports? Y / N How often do they exercise?_____
What types:_____
How much TV do they watch a week? 0-5 / 5-10 / 10-15 / 15-25 / 25+
What type of TV shows/movies do they like?_____
What do they like to do?_____

Relationships (circle one):

With father: Good / OK / Bad Explain:_____
With mother: Good / OK / Bad Explain:_____
With siblings: Good / OK / Bad Explain:_____
With teacher: Good / OK / Bad Explain:_____
With classmates: Good / OK / Bad Explain:_____
Behaviour difficulties? _____
Stresses? _____

Any Further Comments or Concerns?

_____
_____
_____