

## Welcome to *The Prana Group* & Congratulations on taking an important step to creating change in your Child's health!

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Please complete the following form and bring it along with any additional paperwork/diagnostics and/or health commentary you would like the Doctor to review with you on your first visit at Prana. If you have any questions please call us at 613.230.0909.

Our ability to draw effective conclusions about your child's present state of health and how to improve it depends, to a significant extent on your ability to respond thoughtfully and accurately to both these written questions & those posed by the Doctor during the consultation. Health issues are usually influenced by many factors. Accurately assessing all these factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help us to identify the underlying causes of your child's health & also assist us to formulate a treatment plan when appropriate.

### The First Visit

The visit begins with an extensive analysis of your child's level of health. We will determine the current health status and gather further information through appropriate exams and diagnostics to help us determine the underlying cause of current & potential health challenges.

### Additional Visits

A second visit is usually scheduled for your Report of Findings. During this visit the Doctor will discuss the exam findings, the cause or severity of your child's problem and outline a personalized, step by step program of care.

### Our Goal

Our goal is to help our patients live the most vital and productive lives possible by creating personalized, step-by-step health, vitality and longevity programs that address their health needs.

### Health Attitudes

Your attitude about health is as important to us as the specific reason you have consulted The Prana Group on your child's behalf. Below are three prevalent health attitudes. Please mark the one that most closely reflects your personal values.

- Treatment ONLY.
- Prevention.
- Maintaining Health.

### Your Goal

It is important that we understand your primary reason for seeking care. Please mark the one that most closely reflects the reason for your child's visit.

- Chiropractic Rehabilitation
- Natural/Functional Medicine
- Patient Advocacy Consultation
- Wellness Check-up

### Where are we located?

The Prana Group is located at 151 Second Ave. just west of Bank Street in the heart of the Glebe. We are located just behind the Urban Pear Restaurant on the ground level. You will see our sign as you turn into the parking lot. Parking is complimentary.

Thank you. And again, we look forward to a healthy and mutually satisfying relationship with you and your family.

Dr Tamara MacIntyre  
Chiropractor & Doctor of Natural Medicine

**The Prana Group  
New Patient Intake Form 2007**

Last Name: _____			First: _____			Middle: _____		
Age: _____		Birth date (m/d/y): _____			Gender: (circle one) Female Male Other			
Address: _____								
Primary Contact: _____			Home Phone: _____		Work Phone: _____		Cell Phone: _____	
Email Address: _____								
Parent(s) Name(s): _____				Secondary Contact Number: _____				
Legal Guardian: _____				Relationship to New Patient: _____				
Number of Sibling(s) & Age(s): _____								
Other nearest Relative or Contact Person: _____						Phone No. _____		

How did you discover Prana? \_\_\_\_\_ If referred, name of the person who referred you: \_\_\_\_\_

Has your child received Alternative health care in the past? (circle one) Yes No Specialty: \_\_\_\_\_

If Yes, how would you describe your experience? \_\_\_\_\_

Please describe the reason for previous care: \_\_\_\_\_

Name of your Medical Doctor: \_\_\_\_\_

What other health care providers are you seeing, and their specialty? \_\_\_\_\_

What diagnoses have you been given: \_\_\_\_\_

How do you hope your child will benefit from care at The Prana Group?

- Improvement of physical symptoms
- Improvement of emotional/mental symptoms
- Improvement in their ability to respond to stress/anxiety
- Overall improved quality of life
- I will learn more about health and the human body which will ultimately benefit my child's health
- Other: \_\_\_\_\_

Please rank current & ongoing problems by priority and complete:

Describe Problem	Date	Mild/Mod/Severe	Treatment Approach	Success
<b>Example:</b> Excema	Jan'06	Moderate	Diet & Steroid cream	Moderate
1.				
2.				
3.				
4.				
5.				

Please continue on other side of paper or separate sheet if necessary.

In general, would you say your child's health is - check one:

Excellent                      Very Good                      Good                      Fair                      Poor

Compared to one year ago, how would you rate your child's general health now?

- Much better than one year ago
- Somewhat worse now than one year ago
- Somewhat better now than one year ago
- Much worse than one year ago
- About the same

**The Birth**

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Normal Vaginal                      Breech                      Forceps                      Vacuum extraction  
 Home Birth                      Hospital                      Birthing Centre  
 Cesarean    If yes, for what reason was a cesarean section performed: \_\_\_\_\_

Pregnancy problems: \_\_\_\_\_

Labour or delivery problems: \_\_\_\_\_

Congenital Defects / Anomalies: \_\_\_\_\_

APGAR scores (after 5 minutes): \_\_\_\_\_

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

Birth length: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Was there presence at birth:

Meconium                      Cyanosis (blue)                      Jaundice (yellow)

Has or was this child been breastfed?                      Yes    No

If yes, please provide details. (i.e. explain for how long, any difficulties, etc.): \_\_\_\_\_

**Immunization Dates**

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Current & up to date on all Immunization/Vaccinations

Hep B    \_\_\_\_\_                      OPV    \_\_\_\_\_                      MMR    \_\_\_\_\_  
 DPT    \_\_\_\_\_                      HIB    \_\_\_\_\_                      VAR    \_\_\_\_\_

**Childhood Diseases**

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	Date		Date
Measles	_____	Chickenpox	_____
Mumps	_____	Whooping cough	_____
Other:	_____		

Date and purpose of last MD visit: \_\_\_\_\_

**Developmental Assessment**

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**NOTE: ONLY complete this section if your child is between the age Birth to 6 years of age. Begin identifying the actions performed by your child at least 4 months ago.**

Check all that apply:

2 months	_____ keeps hands fisted	_____ Smiles responsively
	_____ Lifts head for several seconds	_____ Begins to vocalize
3 months	_____ Lifts head above body plane	_____ Watches own hands
	_____ Turns head toward object	_____ Smiles & vocalizes in response

4 months	_____ Sits with head steady	_____ Turns head toward sound
	_____ Reaches for objects	_____ Smiles spontaneously
5-6 months	_____ Lifts head while supine	_____ Babbles
	_____ Exhibits no head lag	_____ Localizes direction of sound
7-8 months	_____ Sits alone in tripod fashion	_____ Mouths all objects
	_____ Feeds self cracker	_____ Non specific "dada", "baba"
9-10 months	_____ Sits well without support	_____ Waves "bye-bye"
	_____ Stands holding on	_____ Drinks from cup with assistance
11-12 months	_____ Walks with assistance	_____ Uses 2-4 words with meaning
	_____ Crawls well	_____ Assists with dressing
13-15 months	_____ Walks by self; falls easily	_____ "Dada"/"Mama" specific
	_____ Cruises	_____ Points to things wanted
18 months	_____ Climbs stairs with assistance	_____ Feeds self
	_____ Throws ball	_____ Uses many intelligible words
24 mo / 2yrs	_____ Kicks ball	_____ Handles spoon well
	_____ Runs; climbs stairs well	_____ Speaks 2-3 word sentences
30 mo / 2.5 yrs	_____ Jumps	_____ Knows full name
	_____ Walks on tiptoes	_____ Recognizes three colours
36 mo / 3 yrs	_____ Pedals tricycle	_____ Walks up stairs alternating feet
	_____ Stands on one foot	_____ Knows age & sex
48 mo / 4 yrs	_____ Throws ball overhand	_____ Buttons large buttons
	_____ Climbs well	_____ Plays with several children
60 mo / 5 yrs	_____ Skips	_____ Dresses & undresses

**Previous Medical History**

Has this child ever suffered from:

Anemia	Constipation	Headaches	Orthopedic problem
Arm problems	Convulsions	Heart trouble	Paralysis
Arthritis	Diabetes	Hyperactivity	Poor appetite
Asthma	Diarrhea	Hypertension	Rheumatic fever
Backaches	Digestion problems	Jaundice	Ruptures/hernias
Bed wetting	Dizziness	Joint problems	Sinus trouble
Behaviour problems	Excema	Leg problems	Skin problems
Broken bones	Fainting	Muscle jerking	Sugar levels
Chronic earaches	Frequent Infections	Neck problems	Tuberculosis
Colds/Flu	"Growing pains"	Neuritis	Walking problems

Y/N	Allergies/Sensitivities (please specify)	Allergy Tested/confirmed Y/N	Typical Reaction	Typical Treatment
	Food:			
	Chemicals:			
	Drugs, Medications:			
	Dust, moulds:			
	Animal hair/dander:			
	Grasses, weeds, pollen			
	Others:			

Has this child been treated for an accident or emergency?      Yes      No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Has this child ever has surgery?      Yes      No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Is this child on any medication currently? Yes No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Please list any medication regime that your child has undergone, the approximate date(s) and for what purpose the medication was prescribed. \_\_\_\_\_  
 \_\_\_\_\_

Please list any vitamins, nutritional supplements and/or any dietary considerations: \_\_\_\_\_  
 \_\_\_\_\_

Is there anything else we should know about this child? Yes No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**Family Health History**

Please list the medical history of any family member & their relation to you (i.e. mother, father, sibling, grandparent):

Relation	Age	State of Health	Age of Death	Cause of Death	Check (x) if your blood relatives have/had: Disease	Relationship
Mother					Arthritis, gout	
Father					Allergies, Asthma, Autoimmune	
Sister(s)					Cancer, tumour	
					Chemical Dependency	
					Diabetes	
					Digestive Disorder	
					Emotional Disorder	
					Genetic Disorder	
Brother(s)					Heart Disease, Stroke	
					High Blood Pressure	
					Kidney or Liver Disorder	
					Lifestyle related illnesses	
					Thyroid problem	
				Other:		

**Family Environment**

Comments:

Do you or anyone in the home smoke? Yes No \_\_\_\_\_  
 Do you have a healthy diet? Yes No \_\_\_\_\_  
 Does your family exercise regularly? Yes No \_\_\_\_\_  
 Does your child sleep well at night? Yes No \_\_\_\_\_  
 Is your family life stressful? Yes No \_\_\_\_\_  
 Is your child's life stressful? Yes No \_\_\_\_\_  
 If yes, please identify the factors that contribute to the stressful situation(s) and explain: \_\_\_\_\_  
 \_\_\_\_\_

Can you think of any other habit/activity that has a positive or negative effect on your child's health? Yes No

Has your child experienced any of the following health, treatment or healing modalities?

If so, please describe when you went, for how long, and what the end results have been.

Massage \_\_\_\_\_

Reiki/Energy work \_\_\_\_\_

Emotional therapy/psychotherapy \_\_\_\_\_

File No. \_\_\_\_\_

Music/Dance/Sound/Light/Aromatherapy \_\_\_\_\_  
Naturopathy/Homeopathy/Herbalist \_\_\_\_\_  
Ayurvedic Medicine/Acupuncture \_\_\_\_\_  
Nutritional Counselling Therapy \_\_\_\_\_  
Craniosacral Therapy \_\_\_\_\_  
Other: \_\_\_\_\_

### **Health Care at The Prana Group**

The Prana Group offers a unique health care approach. Our goal is to bridge the gap between traditional medicine & natural health care. While other professions are concerned with changing the environment to suit a weakened body, The Prana Group focuses on strengthening the body to adapt to the environment. We accomplish that by identifying the underlying cause of health challenges and then by creating a step by step plan to help you regain your child's health. Prana is dedicated to providing an exceptional health experience for everyone. We look forward to helping you create change in health and life.

Again, if you have any questions regarding this form or starting care at Prana, please call us at 613.230.0909 OR visit our website at [www.thepranagroup.com](http://www.thepranagroup.com).

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

New Patient Parent's/legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_