NEW EARTH WELNESS

CLIENT CONSENT TO TREATMENT All information is kept confidential and secure

Child's Name: _____

D.O.B. (mm/dd/yyy) _____

Name of Parent (Guardian) _____

Telephone: Home: _____

Cell: _____

E-Mail Address: _____

Address: (Street): _____

City, Province, Postal Code: _____

Emergency Contact: _____

Relation _____

Are Parents divorced or separated? ☐ No ☐ Yes

If Yes, with whom does the child reside? _____

Birth History

Weight: _____ Height: _____ Type of Birth: ☐ vaginal ☐ caesarian

Any complication to mother or baby? _____

Term: ☐ premature ☐ to term ☐ late ☐ induced

Neonatal History (check any that apply)

☐ Jaundice ☐ Colic

☐ Heart Problems ☐ Respiratory Problems

☐ Other _____

Nutrition

Was child breast fed ? ☐ No ☐ Yes

What age were foods introduced? _____ Any reactions? ☐ No ☐ Yes

Does child have a good appetite? ☐ No ☐ Yes How many meals per day _____

Does the child have any diet restrictions? ☐ No ☐ Yes

Education

Type of School ☐ Public ☐ Private ☐ Home ☐ Other:

Grade _____ Does child enjoy school? ☐ No ☐ Yes

What subjects does the child enjoy? _____

What subjects does the child dislike? _____

Habits

Does child exercise regularly? ☐ No ☐ Yes

What activities? _____

How much time does the child spend outdoors weekly? _____

How much sleep per night? _____ Does child wake feeling rested? ☐ No ☐ Yes

Do they have: ☐ Nightmares ☐ Night Terrors

Do they read books? ☐ No ☐ Yes Do they make friends easily? ☐ No ☐ Yes

What are the child's interests? _____

_____

What are the main concerns that bring you here today? List as many as applicable and in order of importance.

Has anyone assisted you previously for this concern? ☐ Yes ☐ No

How did you hear about New Earth Wellness? ☐ Family/Friend ☐ Social Media ☐ Web ☐ Advertising ☐ Other

Has your child experienced *any* of the conditions below? List all whether now or in the past.

Mental / Emotional	**Skin**	**Nose / Sinuses**	**Head & Ears**
☐ Anxiety/Fears	☐ Rashes	☐ Frequent Colds	☐ Headaches
☐ Depression	☐ Easily Bruised	☐ Seasonal Allergies	☐ Fever
☐ Weeps Easily	☐ Hives	☐ Chronic Runny Nose	☐ Earaches
☐ Mood Swings	☐ Acne	☐ Sinus Problems	☐ Loss of Hearing
☐ Poor Concentration	☐ Eczema		☐ Dizziness / ringing
☐ Memory Problems	☐ Itching		☐ Hair Loss

Mouth / Throat	**Immune**	**Respiratory**	**Cardiovascular**
☐ Frequent Sore Throat	☐ Frequent Infections	☐ Shortness of breath	☐ Palpitation
☐ Cavities	☐ Swollen glands	☐ Asthma	☐ Chest Pain
☐ Sores in Mouth	☐ Slow wound healing	☐ Frequent cough	
		☐ Bronchitis	
		☐ Wheezing	

Gastrointestinal	**Speech / Language**	**Other (Specify)**
☐ Stomach Aches	☐ Down Syndrome	
☐ Diarrhea	☐ Stuttering	
☐ Constipation	☐ ADHD/Executive Function	
☐ Bloating /gas	☐ Emotional Regulation	
☐ Change in appetite	☐ Trauma/Brain Injury	
☐ Change in thirst	☐ Slurred Speech	

PERSONAL Medical History: Are there any other medical conditions we should be aware of? ☐ Toxic Exposure

☐ Seizure ☐ Diabetes ☐ Surgeries (metal plates/screws/rods) ☐ Injuries/Accidents

☐ Other: _____

FAMILY Medical History: ☐ Diabetes ☐ Heart Condition ☐ Alzheimer's Disease/Dementia ☐ Cancer

☐ Other: _____

_____

List all medications, herbs & supplements currently taken (include specific purpose if applicable)

Medications	**Purpose**	**Herbs & Supplements**	**Purpose**

The recommended daily water intake beginning the day before the 1st session and for 5 – 7 days after is FIVE 8 oz glasses. Do you expect any difficulty with this? ☐ No ☐ Yes

If **Yes,** Reason: _____

Do you drink purified or filtered water? ☐ Yes ☐ No

How do you rate your child in the following categories? **1 = very low** **5 = very high**

Pain Level ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Stress Level ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Energy Level ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What best describes the child's current state of physical health? ☐ Excellent ☐ Good ☐ Average

☐ Improving ☐ Declining ☐ Serious ☐ Debilitated

Describe your home environment most of the time? ☐ Peaceful ☐ Stressful

Does your child have trouble concentrating or "brain fog"? ☐ Yes ☐ No

Would you consider your child's eating habits/nutrition? ☐ Excellent ☐ Average ☐ Needs Improvement

Is your child sensitive to light or loud noise? ☐ No ☐ Yes Explain: _____

Regaining and maintaining your child's well being requires a strong personal commitment. How ready will they be to make lifestyle, diet or attitude changes that may be necessary to good health?

☐ Ready ☐ Somewhat ☐ Not looking to make changes

I have read and completed the form to the best of my knowledge and understand the questions being asked on this form are being asked to better assess my current circumstances relating to my well being.

I further understand that I am voluntarily agreeing to having a relaxation therapy session. The services provided by New Earth Wellness are not intended to diagnose, treat, cure, or prevent any disease.

_____ _____

Signature of Parent /Guardian Date