

**WELLNESS FORM**

1. Child Full Legal Name: Click or tap here to enter text.

**FAMILY INFORMATION**

2. Parent’s Marital Status:  Single Married Separated Divorced  Other

3. Names and Birth Dates of other children: Click or tap here to enter text.

4. Mother’s Place of WorkClick or tap here to enter text.:  Full-Time  Part-Time

5. Father’s Place of Work: Click or tap here to enter text.  Full-Time  Part-Time

**HEALTH INFORMATION**

6. Doctor’s Name: Click or tap here to enter text. Phone Number Click or tap here to enter text.

7. Previous Doctor’s Name: Click or tap here to enter text.Phone Click or tap here to enter text.

8. Are your child/youth health records on file at Alberta Health Services Community Health Centre? Yes  No

**If No**, where are your child’s health records located.Click or tap here to enter text.

9. Are your child/youth immunizations up to date? Yes  No

If No, please state reason.Click or tap here to enter text.

10. Please give the name of person and type of therapy that your child has previously or is currently . receiving:

a) Name: Click or tap here to enter text. Therapy: Click or tap here to enter text.

Phone: Click or tap here to enter text.

has previously seen  is seeing is on waiting list has applied to see

b) Name: Click or tap here to enter text. Therapy: Click or tap here to enter text.

Phone: Click or tap here to enter text.

has previously seen  is seeing is on waiting list has applied to see

11. Are there any health problems or concerns that we should know about? Yes  No

If yes, please provide information here: Click or tap here to enter text.

12. Does your child/youth have any allergies (food, medication, or other)? Yes  No If yes, please note:

Allergy: Click or tap here to enter text. Triggers/Reaction: Click or tap here to enter text. Treatment Click or tap here to enter text.

Asthma: Click or tap here to enter text. Triggers/Reaction: Click or tap here to enter text. Treatment Click or tap here to enter text.

Exema: Click or tap here to enter text. Triggers/Reaction: Click or tap here to enter text. Treatment Click or tap here to enter text.

Is medication needed at school.  Yes- fill out medical form from your child’s educator No

13. Has your child/youth had? Please check with an X any of the following that apply:

Mumps Red Measles German measles  Croup

Chicken Pox Scarlet Fever  Whooping Cough  Diphtheria

Pneumonia Bronchitis Tonsillitis  Polio

Convulsions Seizures Ear Aches  Frequent Colds

14. Sleep / Toileting / Eating Problems? Click or tap here to enter text.

15. Problems at birth? Yes No

16. Have you ever had your child/youth hearing tested? Yes