

**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? [x] Yes [ ]