NeuroWellness

Child/Teen Intake Form and Medical History

Directions for Parent/Guardian: In order for us to fully evaluate your child or teenager, please fill out the following intake form and medical history to the best of your ability. We realize we're asking for a lot of information and you may not remember or have access to all of it, but please do the best you can.

PATIENT IDENTIFICATION

Child/Teen Name _________________________ Birth Date _______________ Age ______ Sex ____

School ________________________ Grade ____

Natural Mother ______________________________ Natural Father _____________________________

Address ____

City ___________________________ State _______ Zip ____

Home Phone # ________________ Parent Work # __________________ (specify) mom or dad

Primary Guardian (with whom is the child currently living?) _______________________________________

Email Address for Primary Guardian _____________________________________

REFERRAL SOURCE

How did you hear about NeuroWellness? ____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

____

____

____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

What do you want NeuroWellness to do for your child, yourself or your family?

____

____

____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR HISTORY

(Please list any contact with other professionals, medications, types of treatment, etc.)

____

____

____

____

NeuroWellness
MEDICAL HISTORY

Name: ________________________________ Date: ______

Current medical problems/medications: ____

____

Past medical problems/medications: ____

____

Other doctors/clinics seen regularly: ____

Any history of head trauma? (Describe): ____

Ever any seizures or seizure like activity? ____

Any periods of spaciness or confusion? ____

Prior hospitalizations (place, cause, date, outcome): ____

____

Allergies/drug intolerances (describe):____

Approximate number of rounds of antibiotics your child has been given ___________

Present Height _______ Present Weight _______

A. Pregnancy and Birth

Mother's age at birth_______________________

Maternal illness during pregnancy?	No	Yes
Any medications taken?	No	Yes
Was the baby on time (< or >37 wks)?	No	Yes
Was the baby breech?	No	Yes

What was the birth weight?_________________

Did the baby have any trouble while in the hospital (jaundice, infection, breathing problems)?	No	Yes

If so, what kind? ____

B. Past Medical History

Where was your child's last check-up? ____________________ When? ________________

Allergic reaction to meds, food, insects?	No	Yes	Which ones? _______________________
Any serious reaction to immunizations?	No	Yes	Which ones? _______________________
Any hospitalizations besides birth?	No	Yes	For what? _________________________
Any serious injuries?	No	Yes	What kinds? _______________________

C. Family History

Are the child's parents in good health?	No	Yes

Circle any diseases that this child's parents, grandparents, siblings, aunts, uncles, or cousins have had:
Anemia, asthma, allergies, eczema, diabetes, high blood pressure, heart trouble, high cholesterol, tuberculosis, mental illness, drug problems, inherited illnesses, cancer, AIDS, learning disorders, ADD/ADHD, strabismus

List age sex, and gender of siblings :____

Have any of your children died?	No	Yes

D. Feeding and Nutrition

Was there severe colic or any unusual feeding problems during the first 3 months?	No	Yes

If breast fed, for how long? _________________

Does your child take vitamins or fluoride?	No	Yes
Do they use homeopathic or herbal medicines?	No	Yes

E. Review of Systems

Has your child had:

Frequent ear infections?	No	Yes
Eye problems, glasses?	No	Yes
Frequent colds or sore throats?	No	Yes
Chickenpox?	No	Yes
Asthma, pneumonia, recurrent cough?	No	Yes
Heart murmur or heart problems?	No	Yes
Problems with urination, urinary tract infections?	No	Yes
Frequent diarrhea or constipation?	No	Yes
Convulsions or other nervous system problems?	No	Yes
Eczema, hives, or other skin problems?	No	Yes
Anemia or other blood problems?	No	Yes

Please list any other medical problems:

____

____

List any sub-specialists your child has seen:

____

F. Development/Behavior

Age your child sat alone? _________________

Age your child walked alone? _____________

Were they saying words by 18 months?	No	Yes
Do they have trouble sleeping?	No	Yes
Have they had any trouble in school?	No	Yes
Do they get along with other children?	No	Yes

Circle if your child has had any of the following: *thumb sucking, bed wetting, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline*

G. Safety/Environment

Are the parents of the child: *married, divorced, separated, deceased*

Is your child adopted?	No	Yes

The child is also in: *day care, preschool, with nanny, with relatives*

Are there any pets at home?	No	Yes
Are there smokers in the child's home?	No	Yes
Do you have a pool, spa, or pond?	No	Yes
Does your child always wear a helmet when bicycling or skating	No	Yes
Does your child always use a car seat/seatbelt?	No	Yes

H. Records

Do you have a record of immunizations?	No	Yes

NeuroWellness, Inc.

Client Consent

This Client Consent ("Consent") will enable the Client to make a written confirmation of some of the more significant information NeuroWellness has provided regarding its health services.

1. **Services:** Client understands that NeuroWellness, Inc. (NW) is a nutrition-based neuroscience company comprised of Ph.D.s and other trained practitioners. NW does not prescribe medication nor are any of its practitioners, protocols or products developed to diagnose, treat, cure or prevent any disease. As such, clients may or may not work directly with a physician while working with NW. However, when amino acid protocols are used, the initial dosage and any recommended modifications are provided by CHK Labs of Duluth, MN, and Dr. Marty Hinz[t1], MD. Many NW clients choose the natural, healthy protocols offered by NW because they desire alternative solutions to their health challenges without the often negative side-effects of prescription drugs. The NW protocols are designed to strengthen the body's immune and restorative systems, as well as increase neurotransmitter production.

2. **Risks/Benefits:** Dr. Marty Hinz, MD, the patent holder of the amino acid formulas, has designated NW as an authorized caregiver. Dr. Hinz and his NeuroResearch, Inc. have performed extensive testing on the risks associated with amino acid supplementation. As is documented on his website, www.neuroassist.com, amino acid supplementation produces fewer negative side effects than a sugar pill (placebo). The potential benefits are many, including elimination of negative symptoms associated with many neurotransmitter deficiencies. All products sold by NW are nutritional supplements manufactured by 3rd party contractors who have performed their own extensive safety and quality control research.

3. **Complications; Unforeseen Conditions; Results:** Client is aware that his/her body is unique and the nutritional protocols used by NW may not be effective or may take time and effort before they become effective. The NW products and protocols may not be better than, or even as good as, alternative approaches. I further acknowledge that no guarantees or promises have been made to me concerning the results of the Services described in Part 1 above.

4. **Release:** Client, having received and acknowledged this Consent, holds harmless, releases and forever discharges NeuroWellness, Inc., its shareholders, officers, directors, advisors, managers, members, employees, agents, affiliates, successors, professionals and assign's heirs, successors, agents and assigns, from and against any and all damages, injuries, claims, demands, costs, expenses, debts, liabilities, judgments, actions and causes of action of whatever kind and nature arising out of, resulting from, or in any way related to the Services as set forth in this Consent, including, but not limited to, all claims for contract damages, tort damages, breach of duty, conversion, special, general, direct and consequential damages, compensatory damages, loss of profits, injury to persons or property, punitive damages, attorney fees and any and all other damages of any kind or nature.

5. **Acknowledgments:** The Services, including the potential benefits and risks associated therewith, have been explained to Client. Client understands what has been discussed as well as the contents of this Consent. Client has been given the opportunity to ask questions, and has received satisfactory answers.

6. **Consent to Services:** Having read this form and talked with the professionals involved, Client's signature below acknowledges that Client does hereby voluntarily give his/her authorization and consent to the performance of the Services described in Paragraph 1 above. The NW and/or its associates, assisted by personnel and other trained persons, are responsible for the Services rendered. Client also consents to any blood and urine testing done in support of the Services. Client understands that personal information about Client will be kept strictly confidential unless Client authorizes otherwise in writing.

Date: ___/___/___

____________________ NW Staff Name (printed)	____________________ Parent/Guardian Name (printed)
____________________ NW Staff Signature	____________________ Parent/Guardian Signature

Behavioral Rating - Scale for Parents Date__________________

Child's Name ________________________ ID Number_____________________

		Never or rarely	Sometimes	Often	Very often
1.	Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2.	Fidgets with hands or feet or squirms in seat.	0	1	2	3
3.	Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4.	Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5.	Does not seem to listen when spoken to directly.	0	1	2	3
6.	Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7.	Does not follow through on instructions and fails to finish work.	0	1	2	3
8.	Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9.	Has difficulty organizing tasks and activities.	0	1	2	3
10.	Is "on the go" or acts as if "driven by a motor."	0	1	2	3
11.	Avoids tasks (e.g., schoolwork, homework) that require sustained mental effort.	0	1	2	3
12.	Talks excessively	0	1	2	3
13.	Loses things necessary for tasks or activities.	0	1	2	3
14.	Blurts out answers before questions have been completed.	0	1	2	3
15.	Is easily distracted.	0	1	2	3
16.	Has difficulty awaiting turn.	0	1	2	3
17.	Is forgetful in daily activities.	0	1	2	3
18.	Interrupts or intrudes on others.	0	1	2	3