Axiom Health

104-3040 TUTT STREET, Kelowna, BC V1Y 2H5

Welcome to the office of Dr. Alana Berg, ND and Dr. Audrey Wolter, ND, of Axiom Health Clinic! We are honored that you have chosen us in your search for optimal health. Please fill out and sign the attached forms to the best of your ability, and bring them to the initial appointment. It will aid in your assessment of your present health, and facilitate in your process of healing.

If you wish to cancel or reschedule your appointment; please do so **48 hours** or more before your appointment. We do reserve the right to **charge full cost** of the visit for missed appointments, or if less than 24 hrs is given for cancellations. We will confirm your appointment 2 days prior to your visit by email reminder, please ensure you email is correct. If you are undergoing any treatments, please do not come on an empty stomach, as this may raise some of the risks associated with therapies. If you have any questions, please call our office or speak to the reception staff. We look forward to growing with you!

Note: many of our patient are sensitive to environmental substances; therefore, we ask that all patients refrain from wearing scented hairsprays, colognes, perfumes aftershaves, etc., on the day of your appointment.

Payment Requirements: Appointments must be paid for at the time of service. We accept VISA, MC, Debit, and cash.

Records: We keep a record of your health care services. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to. You can obtain copies of the files for a small fee upon signing an authorization form. Please allow up to 10 working days to process the request.

Insurance: Axiom Health does not directly bill insurance companies. You may submit your paid invoice to your insurance company for reimbursement. We are also not a Government Funded healthcare provider, and no reimbursement will be honored by this organization.

I understand that I will have asked a Dr. Berg and Dr. Wolter of Axiom Health Clinic for help and that she will help to the best of her ability.

I have read and understand the above statements.

_____	_____	_____
Print Name	Signature (signed by guardian if under-age)	Date

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PEDIATRIC INTAKE FORM

Patient Info:
First Name:_____ Last Name:_____
Age:_____Sex:_____
Address:_____
Phone:_____ DOB: _____
Referral:_____
Guardian(s):_____
Person who is filling out this form: _____
Relation:_____

Contacts Name:_____
Phone:_____
Relation:_____

Other health care practitioners
Name:_____ Name:_____
Phone:_____ Phone:_____

Child's Health Concerns in order of importance:
1. _____
2. _____
3. _____
4. _____
5. _____

Present Medical Information:
Height:_____ Weight:_____

Past Medical History

Conception:
Mother health: _____
Father health: _____
Number of Previous Pregnancies: _____ Number of miscarriages: _____
Abortions:_____
Any medical interventions (medication, artificial insemination, etc.) _____
_____

Pregnancy
Pregnancy length:_____ Weight gain:_____
Mother's age:_____
Illness or infections during:_____ medication associated:_____
Toxic exposures:_____ Travel:_____
Stress:_____ Work:_____ when stopped:_____

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Diet:_____ Cravings: _____
Conditions associated:
Other:_____
Pre-natal care by:_____Supplementation:_____
Medications (Rx and OTC):_____

Labour
Labour length:_____ Complications:_____
Birth:_____
Medications administered:_____

Infancy
Birth weight:_____ height:_____ length:_____ head circumference: _____
APGAR score: _____
Natal disease: _____ Hospitalization associated:_____
Breast fed: _____ how long?_____ Problems associated: _____
Formula: _____ how long?_____ Any reactions: _____
Any adverse reactions with food introduction: _____
Milestones (ages)
Sitting up:_____Crawling:_____
Talking:_____Walking:_____
Teething:_____Sentences:_____

Childhood Illnesses:
Health as a child: (1) Poor to (10) Excellent_____ Explanation: _____

___ Rheumatic fever	___ German Measles	___ Polio
___Allergies	___ Chicken pox	___ Mumps
___ Asthma	___ Ear infections	___ Skin conditions

Vaccinations: (please check all that apply)

( ) DPTP (Diphtheria, Pertussis, Tetanus, Polio)	( ) Meningococcal
( ) Booster (usually DT)	( ) Pneumococcal
( ) Chicken pox	( ) H. Influenza B
( ) MMR (Measles, Mumps, Rubella)	( ) HPV
( ) HBV (Hepatitis B Vaccine)	( ) Shingles
( ) Other (flu shot, etc)	

Family History:
Has anyone in your immediate family had any of the following:

___Cancer	___High blood pressure	___Diabetes
___Heart Disease	___Allergies	___Arthritis
___Epilepsy	___Glaucoma	___Mental Illness
___Alcoholism	___Stroke	___Obesity

Other

_____
_____