



WELLNESS FORM

1. Child Full Legal Name:

FAMILY INFORMATION

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

3. Names and Birth Dates of other children:

4. Mother's Place of Work Full Time Part Time

Work Phone #:

5. Father's Place of Work: Full Time Part Time

Work Phone #:

HEALTH INFORMATION

6. Doctor's Name: Phone Number:

7. Previous Doctor's Name: Phone Number:

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.

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

If No, please state reason.

10. Please give the name of person and type of therapy (speech, occupational therapy, physical therapy etc...) that your child has previously or is currently receiving:

a) Name: Therapy: Phone:

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

b) Name: Therapy: Phone:

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

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

Allergy: Triggers/Reaction: Treatment:

Asthma: Triggers/Reaction: Treatment:

Exema: Triggers/Reaction: Treatment:

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

12. 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?

15. Problems at Birth? Yes No

16. Have you ever had your child's hearing tested? Yes No

Other medical information: