NATUROPATHIC PERSPECTIVES

Redefining Your Health

Adolescent Intake Form

Name _____ Today's Date _____
Date of birth _____ Sex M / F

Address:_____
_____
_____

E-mail Address for naturopathic correspondence: _____

May we email you appointment reminders? Yes / No

Signature:_____ Time:_____ Date:_____ Witness:_____

Telephone numbers: Main Phone number: _____

Secondary number: _____

May we leave messages relating to your visits? Yes / No

Emergency contact:

Name: _____

Phone number: _____ Relation: _____

How did you hear about our Clinic: _____
Referred by: _____

Other health care providers (i.e. Medical Doctor, Pediatrician, Chiropractor) you are seeing:

1. _____ 2. _____ 3. _____
   _____ _____ _____
   _____ _____ _____

   (____)_____ (____)_____ (____)_____

What are your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

If you are female are you currently pregnant? Yes / No (Please circle one)

Medical history

How would you describe your general state of health? (please circle)
Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates.

_____
_____
_____
_____

Do you have any allergies (medicines, environmental, etc.)?

_____
_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

Please list past prescription medications.

_____
_____
_____
_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (please circle)

Aspirin/Laxatives/Antacids/Diet pills/Birth control pills/implants/injections
Alcohol—how much/day or week _____
Tobacco—form and amount/day _____
Caffeine—form and amount/day _____
Recreational drugs—what and how often _____

Please indicate what immunizations you have had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when?_____	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other _____

Please indicate if any of the above vaccinations caused adverse reactions:
_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)?
Yes / No _____
_____

<u>Nutritional History</u>

Do you have any food allergies or intolerances? Please list.
_____
_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?
_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (and total quantity) _____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Kidney disease	
Heart disease		Drug abuse or Alcoholism	
High blood pressure		Other mental illness	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Social Patterns

Occupation _____

Hobbies _____

Do you exercise regularly? Yes / No

What do you do for exercise, how much, how often?

_____

_____

_____

Environment

Are you exposed to significant tobacco smoke (work, home, etc.)? Yes / No
Are you frequently exposed to animals (work, pets, etc.)? Yes / No

How is your home heated? _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

How would you describe the emotional climate of your home?

_____
_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____
_____

Adolescents, Please fill in this section yourself:

Menstrual History (for females to complete)

Have you started your menses (your period)? Y / N If yes, at what age did it start?_____

How many days does your period last?_____

How many days from the start of your period to the start of the next one?_____

Have you ever missed a period? Y / N If yes, for how many months? _____

Do you have any premenstrual symptoms (please list what they are and when they start during your cycle)?

_____

_____

Social Patterns

Do you have any good friends? Y / N

If yes, do you feel like you can trust these friends?_____

Do you have a job? Y / N If yes, how many hours do you work per week? ____hours/week

Do you enjoy your job?_____

Do you enjoy school? Y / N

Which subjects do you like the most?

_____

Which subjects do you like the least?

_____

Sleep Patterns

How many hours do you sleep at night? _____

Do you feel rested when you wake up? _____

Do you get tired throughout the day? Y / N If yes, at what time? _____

Environment

Do you ever felt pressured to do things you do not want to do (i.e. drugs, sex)? Y / N

Have you ever tried (check all that apply)?

☐ smoking cigarettes ☐ drinking alcohol ☐ drugs, which ones:_____

If you use any of these things regularly, how much and how often? _____

Have you ever been sexually active? Y / N Are you currently sexually active? Y / N

Do you use contraceptives of any kind (e.g. birth control pill, condoms, etc.)? _____

Have you ever had to use a pregnancy test? Y / N

What is your sexual preference (Please circle)? Males Females Both

Is there anything else you would like me to know about? _____

_____

_____

To the best of my knowledge, the information contained in this document is accurate.

Printed Name _____ Date _____

Signature _____