



teen naturopath

www.teennaturopath.com

Confidential Adolescent (10-18 years) Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. The first section may be completed by the patient or a parent/guardian. The second section should be completed by the patient.

Personal Information

Name _____ Date _____

Date of birth _____ Age _____ Gender: Male Female

Address _____ City _____

Province _____ Postal code _____

Phone: Home _____ Work _____ Other _____

Email _____ May we leave messages relating to your visit? Yes No

Other health care providers (Medical Doctor, specialists, chiropractors, etc.)

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Emergency contact person

Name: _____ Relationship: _____

Phone: _____ Alternate number: _____

How did you find out about 360 Health Care?

- Referral from _____ Chatelaine Today's Parent
- Internet search Yellow Pages Other _____

Would you like to receive our seasonal newsletter with information on health and upcoming events? Your email address will not be shared. Yes No



What are the main health concerns you would like addressed?

- 1.
2.
3.
4.

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

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

Three horizontal lines for text entry.

Do you have any allergies or sensitivities (food, medicine, environmental, other)?

Three horizontal lines for text entry.

Please list all current medications, including dosage, duration of use and reason for use.

Table with 4 columns: Medication, Dose, Duration, Reason/ condition treating. Contains 5 empty rows.

Please list all past prescription medications

Three horizontal lines for text entry.



Please list all natural health products (supplements, vitamins, herbs, homeopathics).

Natural Health Product	Dose	Duration	Reason/ condition treating

Approximately how many times have you been treated with antibiotics? _____

Please indicate which vaccinations you have received

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

Please indicate any adverse reactions you may have had to a past immunization

Do you get regular screening exams done by another doctor (PAP, blood tests, etc.)?

- Yes No

Family History

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

- Alcoholism
- Allergies
- Arthritis
- Asthma
- Cancer
- (type _____)
- Depression
- Other mental illness
- Diabetes
- Drug abuse
- Endometriosis
- Epilepsy
- Gallstones
- Heart disease
- High blood pressure
- Kidney disease
- Multiple sclerosis
- Obesity
- Osteoporosis
- PMS
- Skin disease
- Stroke
- Thyroid disease
- Tuberculosis



The following section is to be completed by the patient

Diet

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

Three horizontal lines for text input.

Do you have any food allergies or sensitivities? Please list.

Three horizontal lines for text input.

Describe a typical day's diet.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

List any food cravings regardless of their nutritional value (sweets, salty, water, etc.)

Two horizontal lines for text input.

Education

Are you currently in school? Yes No If yes: Home school Public school Private

What grade are you in? _____

Are you in special education classes (e.g. gifted, at risk program, ESL)? _____

Have you been held back in school? Yes No. What grade? _____

Do you enjoy school? Yes No. Why? _____

What are your favourite subjects? _____

Do you participate in any sports, clubs or other after school activities? _____



Lifestyle and Social History

What are your hobbies? _____

How many hours a week do you engage in the following activities

Table with 5 columns: Activity, Never, 1-4 hours/wk, 4-8hours/wk, More than 8 hours. Rows include Watch TV, Play video games, Use the computer, Play sports, Exercise/ active play, Read.

Other organized time (e.g. piano or music lessons, etc.) _____

Do you exercise regularly? Yes No

What do you do for exercise, how often and for how long? _____

Do you regularly use any of the following?

- Antacids, Aspirin/ Tylenol/ Advil, Birth control pills, Diet pills, Laxatives, Alcohol, Caffeine, Tobacco, Recreational drugs

Are you exposed to significant tobacco smoke at work or home? Yes No

Are you frequently exposed to animals (pets, work, etc.)? Yes No

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

How would you rate your stress levels?

- Overwhelming, High, Moderate, Low, Minimal



How many hours of sleep do you average per night? _____

Do you have difficulty falling asleep? Yes No

Do you have trouble staying asleep? Yes No

Do you wake feeling rested? Yes No

Sexual History

What is your sexual orientation? Heterosexual Homosexual Bisexual Transgendered

Are you now, or have you ever been sexually active? Yes No

If yes, what type of birth control do you use? _____

If yes, have you been tested for sexually transmitted diseases (STDs)? Yes No

Female Patients

Have you started menstruating? Yes No

If yes, at what age did your period start? _____

Is your menstrual cycle regular? Yes No

How many days are your cycles (first day of bleeding to first day of bleeding)? _____

How many days do you have flow/ bleeding? _____

Do you have any of the following symptoms:

- Acne Back pain Breast tenderness Cramps Headaches Heavy flow
- Irritability Mood changes Other _____

If female, are you currently pregnant? Yes No

Have you ever been pregnant before? Yes No

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