teen naturopath

Confidental 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 Dr. Lisa Watson?

❍ Referral from _____ ❍ Chatelaine ❍ Today's Parent

❍ Internet search ❍ Global TV ❍ 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.

_____

_____

_____

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

_____

_____

_____

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

Medication	Dose	Duration	Reason/ condition treating

Please list all past prescription medications

_____

_____

_____

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) ❍ MMR (measles, mumps, rubella) ❍ Influenza
❍ Haemophilus influenza B ❍ Hepatitis A ❍ Hepatitis B
❍ Tetanus booster; when? _____ ❍ Smallpox ❍ Polio
❍ Other _____

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

The following section is to be completed by the patient

Diet

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

_____

_____

_____

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

_____

_____

_____

Describe a typical day's diet.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

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

_____

_____

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

Activity	Never	1-4 hours/wk	4-8hours/wk	More than 8 hours
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 – form and amount/ day _____

❍ Caffeine – form and amount/ day _____

❍ Tobacco – form and amount/ day _____

❍ Recreational drugs – what and how often? _____

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?

_____

_____

_____

_____