

Date: _____

Naturopathic Essentials Health Centre
Confidential Adolescent Intake Form (13 – 19 yrs)

NAME: First: _____ Last: _____ Middle: _____

SEX (✓): male ___ female ___ **BIRTHDATE (Month/Day/Year):** _____ **AGE:** _____

HOME ADDRESS: _____

SCHOOL: _____ **WORK:** _____

Phone home: _____ Phone work: _____

Cellphone: _____ Email: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? Referral Just Walking By Google Ads Internet Search Other: _____

*If you were referred to us by a friend or family member, please give us their name so we may send them a letter of appreciation. _____

**We send newsletters on health issues and other information mailings to all our patients. If you do NOT want to be part of the mailing list, please check here: "No thank you" ___

OTHER HEALTH PROVIDER(S) INFORMATION

Family Physician: _____ Phone: () _____

Other Health Care Provider(s): _____ Phone: () _____

_____ Phone: () _____

Do you have extended medical coverage? _____

YOUR CURRENT HEALTH CONCERNS

What are your main reasons for visiting the clinic in order of importance to you?

1. _____

2. _____

3. _____

4. _____

ALLERGY INFORMATION

Do you have any allergies to any drugs, supplements, herbs, foods, animals or other?

CONTEXT OF CARE OVERVIEW

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

PAST MEDICAL HISTORY

Please indicate which of the following conditions you have had.

- | | | |
|---|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fatigue / Exhaustion / Mononucleosis | <input type="checkbox"/> Nausea /Gas / Irritable bowel |
| <input type="checkbox"/> Allergies /Hay fever | <input type="checkbox"/> Fractures / Fall / Accident | <input type="checkbox"/> Numbness / Tingling / Tremors |
| <input type="checkbox"/> Anemia / Blood Disorder | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Osteoporosis / Disc Damage |
| <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Gastric reflux / Heartburn / Acidity | <input type="checkbox"/> Psoriasis/Fungal Infections |
| <input type="checkbox"/> Asthma / Emphysema | <input type="checkbox"/> Gum & Periodontal disease / Gingivitis | <input type="checkbox"/> PMS / Painful Period |
| <input type="checkbox"/> Autoimmune disease / Lupus | <input type="checkbox"/> Gout | <input type="checkbox"/> Female concerns |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches /Migraines | <input type="checkbox"/> Male Prostate / Erectile |
| <input type="checkbox"/> Candida Thrush /Yeast infections | <input type="checkbox"/> Hearing Loss /Ringing noise/Dizziness | <input type="checkbox"/> Sexually Transmitted Infections |
| <input type="checkbox"/> Constipation/Haemorrhoids/Fissure | <input type="checkbox"/> Heart Disease / Stroke | <input type="checkbox"/> Sinus/Ear Infections |
| <input type="checkbox"/> Depression / Mental illness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sore throat / Tonsillitis |
| <input type="checkbox"/> Anxiety Attacks / Nervousness | <input type="checkbox"/> High Blood Pressure /High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Loneliness/ Grief | <input type="checkbox"/> Incontinence (frequent urination) | <input type="checkbox"/> Frequent Pneumonia/Bronchitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia / Poor sleep | <input type="checkbox"/> Frequent Influenza /Head Colds |
| <input type="checkbox"/> Diarrhea / Giardia /Parasites | <input type="checkbox"/> Kidney Disorders / Bladder Infections | <input type="checkbox"/> Addictions- Smoking/alcohol, etc |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver / Gall Bladder Disorders | <input type="checkbox"/> Abuse (sexual, verbal, physical) |
| <input type="checkbox"/> Eczema / Dermatitis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Trauma / Shock / Shame |
| <input type="checkbox"/> Edema/ /Swollen Ankles | <input type="checkbox"/> Miscarriage / Pregnancy Issues | <input type="checkbox"/> Virus; Herpes, Shingles Warts,
HIV, HPV, Cold sores,
Other_____ |
| <input type="checkbox"/> Poor Circulation /Varicose Veins /
Bruising | <input type="checkbox"/> Jaw / Back / Neck /Hip / Knee
Problems | |

Others (Please List): _____

Tell us about your worst period of health. Why? _____

Please indicate if you have had any hospitalizations, surgeries &/or serious injuries:

CURRENT MEDICATION

Please list all the medications, supplements, herbs and over-counter drugs you are taking.

Medication/supplements/herbs	Dosage	Since	Reason

LIST ALL PREVIOUS MEDICINES: (include how many courses of antibiotics)

FAMILY HISTORY

Please list relatives who have the following conditions.

Condition	Family Members (ie. mom, dad, grandparents, etc)
Addictions (Please specify)	
Alzheimers / Parkinsons	
Allergies/ Hayfever	
Asthma	
Eczema / Hives	
Anemia	
Arthritis	
Cancer	
Diabetes	
Epilepsy	
Heart Disease / Stroke	
High Blood Pressure	
High Cholesterol	
Mental Illness / Depression / Anxiety	
Osteoporosis	
Thyroid Disorder	
Chronic Fatigue / Fibromyalgia	
Autoimmune Condition	
Other	

DIET

Do you have any dietary restrictions? (specify) _____

List food cravings? _____

Please describe your most regular foods OR yesterday's diet:

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

Fruits (eaten daily):

Servings of Vegetables per day (1 cup = 1 serving) : 0 __ 1 __ 2 __ 3 __ 4 __ 5+ __

Red Meat (beef, veal, lamb, goat, pork, sausages, bacon, ham) per week: 0__ 1-2 __ 3-4 __ 5+__

Refined white foods (white bread, white rice, sweet breakfast cereals, pasta, noodles, cookies, pastries, cakes).

Servings per day: 0__ 1-2__ 3-4 __ 5+__

Sugar/candies/chocolate servings per day: 0__ 1-2 __ 3-4 __ 5+__

Water (# cups): __ **Coffee**__ **Tea** __ **Soft Drinks** _____

BOWEL MOVEMENTS per week: _____

SLEEP

Avg. # of hours per night slept: _____

of times you usually wake at night: 0 __ 1__ 2__ 3+__

Do you snore regularly? Yes__ No __

Do you have trouble falling or staying asleep? Yes__ No __ If Yes, why? _____

Do you feel you are well rested when you get up? Yes__ No __ If No, why? _____

On a scale of 1 to 10 (10 as the best), how do you rate your quality of sleep? 0 1 2 3 4 5 6 7 8 9 10

ENERGY

On a scale of 1 to 10 (10 as the best), how do you rate your energy? 0 1 2 3 4 5 6 7 8 9 10

Are your daily tasks affected by you being tired? Yes__ No __ Do you nap during the day? Yes__ No __

WORK: # Hours per week: _____ Do you enjoy your work? _____

EXERCISE: # times per week: _____ Length of time (minutes): _____ What type /sport? _____

MEDITATION: Yes__ No__ **Do you have time to relax daily:** Yes__ No__

ENJOYING LIFE? (√) Definitely __ Mostly Yes __ Not Sure __ Mostly Not __

What STRESSFUL factors (including difficult relationships, moves, deaths, births, marriages, work, finances, past trauma, etc) have you been experiencing over the last year(s)?

Describe your general mood._____

SEXUAL HISTORY:

Sexual preference (circle): Heterosexual Homosexual Bisexual

Are you sexually active? Yes / No If yes, please continue.

Do you use birth control /protection? Yes / No If so, what kinds? _____

Have you ever been tested for STIs/STDs? Results? _____

Do you have any questions or concerns about sex, pregnancy, sexually transmitted infections (STIs), contraception or homosexuality and bisexuality? Please specify. _____

Do you have any dermatological concerns? Please specify. _____

Do you have a close friend or confidant to talk to about your problems? Who? _____

Any problems at school? Home? _____

Do you smoke? Recreational drugs? Alcohol? (specify) _____

Do you have any questions/concerns about your body? _____

FEMALES:

What age did you start menstruating? _____ Regular or irregular cycle: _____

Menstrual cycle length: _____ Duration of flow: _____ Any Clots? _____

How many pads or tampons do you use on your heavy days? _____ Lightest days? _____

List any symptoms that occur with your menses like cramping/pain, bloating, breasts tenderness, fatigue, mood changes, etc.? _____

Are there any other concerns/questions that you would like to address?

Thank you for taking the time to complete this form.