Date: _____

# Naturopathic Essentials Health Centre

## Confidential Adolescent Intake Form (13 – 19 yrs)

**NAME:** First: _____ Last: _____ Middle: _____

**SEX (√): _____ 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.

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

**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 <u>your most regular foods</u> OR <u>yesterday's</u> 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, veil, 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.**