NATUROPATHIC ADOLESCENT INTAKE FORM

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GENERAL

Name:		Date of 1st Visit:		
Date of Birth: dd /mm /yyyy	Age:	Gender:	Height:	Weight:
Address:				
City:		Prov:	Postal Code:	
Phone (home):		Phone (work):		
Phone (cell):		Email:		
Person completing this form:				
Name of Guardian:		Relationship:		
Name of Guardian:		Relationship:		
With whom does this child live?				
Was this child adopted?	If yes, at what age?			

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
3.	4.
Phone:	Phone:
Fax:	Fax:

Please indicate any regular screening tests your child has done:

_____

Date of last screening test or physical exam:

_____

How did you hear about our clinic?

_____

HEALTH HISTORY

Reason for visit (list in order of importance):

_____

_____

_____

_____

_____

How long has the child had this condition?

_____

_____

_____

_____

_____

What type of therapies have you tried in the past for these concern(s)?

q Diet Modification q Vitamins/minerals q Herbs q Homeopathy q Chiropractic q Pharmaceuticals q Other _____

What was the outcome?

_____

Please list all prescriptions, over the counter medications, supplements, vitamins or natural health products the child is **currently** taking, the reason why, and for how long they have been taking them:

Medication/Natural Health Product	Reason Taking	How long

How many times has the child been treated with antibiotics?

_____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year Illness, Surgery, Injury, Major Medical Diagnosis

_____ _____

_____ _____

_____ _____

Please list all allergies: (food, environmental, medications, etc)

_____

_____

Please list any food sensitivities:

_____

_____

Please list any other foods that are excluded from the child's diet and why:

_____

_____

Please check all of the following conditions that your child is currently experiencing (C) or has experienced in the past (P)

Condition	C P	Condition	C P	Condition	C P
Measles	q q	Mononucleosis	q q	Bed Wetting	q q
Chicken Pox	q q	Strep Throat	q q	Anxiety	q q
Headaches	q q	Rubella	q q	Asthma	q q
Mumps	q q	Chronic Runny Nose	q q	ADD/ADHD	q q
Ear Infections	q q	Hives/Rashes/Eczema	q q	Cold Sores	q q
Pneumonia	q q	Temper tantrums	q q	Sinus Problems	q q
Constipation	q q	Coughing/wheezing	q q	Seizures	q q
Scarlet Fever	q q	Colic/gas/cramping	q q	Diarrhea	q q
Tonsillitis	q q	Digestive Difficulties	q q	Frequent Colds	q q

FAMILY HISTORY

_____

Please check any the following that a family member has experienced:

q Arthritis
q Asthma
q Alzheimer's Disease
q Autoimmune (MS, Lupus, etc)
q Cancer
q Depression
q Diabetes
q Eczema
q Drug Addiction/Alcoholism
q Heart disease
q High Blood Pressure
q Migraine headaches
q Psoriasis
q Kidney Disease
q Stroke
q Thyroid Issues
q Mental Illness
q Other _____

DEVELOPMENTAL AND SOCIAL HISTORY

_____

Is your child in: qschool qhomecare qother What grade level? _____

General school/daycare
behaviour/performance:_____

_____

How is the child's behaviour at home?

_____

Does your child have any habits? _____ Any fears?

_____

Has the child been diagnosed with any learning disabilities?

_____

Does your child make friends easily?
_____

Child's interests and favourite activities:
_____

According to your child, do they enjoy these activities?
_____

How many hours/week does your child: Play on the computer or video games? _____ Exercise? _____
Watch television? _____ Read?(not for school) _____

Please write a little about your child's personality?
_____
_____

LIFESTYLE HABITS

_____

What time does your child usually go to bed? _____ Wake up? _____

Does your child have nightmares? Y / N How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc)

_____

Please describe your child's eating behaviours (eg. Good appetite, picky eater, etc.)
_____

Does your child have any strong food cravings or aversions?
_____

Is the child exposed to any of the following on a regular basis?

qtobacco smoke q pets q old building q renovations qchemical fumes qnew building

Please describe:

_____

What is the source of your child's drinking water?
q tap q filtered q distilled q bottled q other _____

Marital status of the child's parents: q Married q Divorced q Separated

How would you describe the emotional climate of the child's home?
_____
_____