1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

ADOLESCENT INTAKE FORM (11 years to 16 years)

Naturopathic medical care requires a healthy relationship between provider and patient. Your responses to the following questions will significantly contribute to your doctor's understanding of you and your health history. ***Please complete in as much detail as you feel is relevant and to the degree that you are comfortable.*** *Thank you!*

PERSONAL INFORMATION:

First Name: ______________________________ Last Name: ______________________________

Date of Birth (mm/dd/yy): _____/______/______ Age: _________ Gender: MALE / FEMALE

MSP Care Card #: ______________________________ Extended Coverage: YES / NO

Contacts (in order of preference):

1) Name: ______________________________ Relationship to Patient: ____________________

Address: ______________________________ City: ____________________ Province: __________

Postal Code: ______________ Email: ____________________________

Phone # (H): ____________________ (Cell): __________________________ (W): ____________________

2) Name: ______________________________ Relationship to Patient: ____________________

Address: ______________________________ City: ____________________ Province: __________

Postal Code: ______________ Email: ____________________________

Phone # (H): ____________________ (Cell): __________________________ (W): ____________________

3) Name: ______________________________ Relationship to Patient: ____________________

Address: ______________________________ City: ____________________ Province: __________

Postal Code: ______________ Email: ____________________________

Phone # (H): ____________________ (Cell): __________________________ (W): ____________________

4) Name: ______________________________ Relationship to Patient: ____________________

Address: ______________________________ City: ____________________ Province: __________

Postal Code: ______________ Email: ____________________________

Phone # (H): ____________________ (Cell): __________________________ (W): ____________________

Okay to leave a message re: appointments? (Please circle) YES / NO

Contact person for appointment reminders: ________________________ Tel: ____________________

With whom does the patient live with? ____

REFERRAL SOURCE - How did you hear about our clinic? (Please check box)

Current patient of CR Chiropractic ____________ Advertising __________

Medical Doctor/Specialist (please provide name): ____________ Website (campbellriverchiropractic.ca OR vitalrootswellness.ca)

Other Health Care Provider (please provide name): __________ Information Session __________

CR Chiropractic Staff ______________ Social Media (Facebook, Twitter, etc) _________

Other: ____

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Name: ______________________ *Date of Birth:* ________________________

Primary Care Provider (ie. Pediatrician, Medical Doctor): ______________________Clinic Number: ____________________

Please list other health care providers the adolescent is currently seeing or working with:

Practitioner Name: _________________________ Practitioner Type: ___________ Contact #: _________________

Practitioner Name: _________________________ Practitioner Type: ___________ Contact #: _________________

What expectations do you have of me as your physician?

____

What expectations do you have from this first visit to our clinic?

____

What is your **main reason** for seeking naturopathic care? If there is a specific health condition, please describe it in detail. (Eg. When was the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and continuation.)

____

____

Current health concerns, listed in order of preference:

1) _______________________________________ 2) _______________________________________

3) _______________________________________ 4) _______________________________________

How would you rate overall health? POOR FAIR AVERAGE GOOD EXCELLENT

How would you rate overall energy? POOR FAIR AVERAGE GOOD EXCELLENT

Current Weight: _____________ Height: _____________ Today's Date: _______________

MEDICAL HISTORY (please check)

Chicken pox:	_______	Pneumonia:	_______	Strep throat:	_______
Measles:	_______	Whooping Cough:	_______	Ear Infections:	_______
Mumps:	_______	Rheumatic fever:	_______	Mononucleosis:	_______
Rubella:	_______	Roseola:	_______	Impetigo:	_______
Scarlet fever:	_______	Bronchiolitis/Bronchitis:	_______	Other (please list):	____________

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list):

____ ____

____ ____

____ ____

____ ____

MEDICATIONS:

Please indicate whether any medication is currently being used (prescription and over-the counter):

____ ____

____ ____

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

Has there ever had an adverse reaction to a medication? Y / N List the Medication: _________________________

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ALLERGIES:

List all (medications, pollens, foods, animals etc.):

____

____

OVER THE COUNTER REMEDIES/SUPPLEMENTS:

List all remedies/supplements (herbal, vitamin/mineral, nutritional, homeopathic etc.) your currently taking:

1.	3.
2.	4.

IMMUNIZATIONS (please check)

MMR (measles, mumps, rubella) _______
Polio _______
DPT (diphtheria, pertussis, tetanus) _____
Influenza (Flu) _______
Smallpox _______

Haemophilus influenza B ______
Hepatitis B _______
Hepatitis A _______
Tetanus booster? When? _______
Pneumococcal (pneumonia) ____

Meningococcal (meningitis) _____
Varicella (chicken pox) ________
Rotavirus _______
Other: _______________________

Any adverse reactions to vaccines: Y / N If yes, please describe: ____

DIET

Are there any food intolerances or allergies? Please list.

____

____

____

Are there any dietary restrictions (religious, vegan/vegetarian, etc.)?

____

____

____

Describe a typical days diet:

Breakfast ____
Snack____
Lunch ____
Snack ____
Dinner ____
Beverages (including quantity) ____

HEALTH AND DEVELOPMENT

How was general health in the first year? (circle) POOR FAIR GOOD EXCELLENT UNKNOWN

Describe current sleep patterns: ____

____

Environmental allergies (if known) ____

How would you describe your Adolescent’s behavior and performance at school? ______________________________

____

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ENVIRONMENT

Please indicate daily environments: (please circle) SCHOOL / DAYCARE / HOME CARE / OTHER: __________

What are some favorite activities? ____

____

Do you exercise regularly? Y / N How much, how often? ___________________________________

____

How much television is watched? ___________________________hrs a day/week

Does anyone in the household smoke? Y / N Are there animals in the home? Y / N

How is the home heated?

Natural Gas ______________ Wood ______________

Oil ______________ Other: _______________

Electric ______________

Do you know of any toxins that you may be regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

____

____

____

How would you describe the emotional climate of the home?

____

____

____

FAMILY HISTORY:

Please indicate whether any of your family members have, or have had, the following:

Condition	**Relative**	**Condition**	**Relative**
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart condition	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid Conditions	

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REVIEW OF SYSTEMS:

GENERAL SYMPTOMS:	**EARS/EYES/NOSE/THROAT:**	**CARDIOVASCULAR:**
Headache	Tonsillitis	Heart murmur
Head injury	Sore Throat	Irregular heart beat
High fevers	Enlarged Glands	Irregular Heart Beat
Chills	Ear discharge	Bleeding gums
Night Sweats	Ear infections	Anemia
Dizzy spells	Mastoiditis	**GASTROINTESTINAL:**
Fainting	Hearing loss	Bloating
Excessive Fatigue	Nose bleeds	Excessive thirst
Nervousness/Anxiety	Ear ache	Excessive hunger
Loss of Weight	Nasal Discharge	Reflux
Allergies	Nose bleeds	No appetite
Nightmares	Sensitivity to light	Belching
Sleep problems	Bad breath odor	Gas (flatulence)
Cries easily	Canker sores	Nausea
Unusual fears	Bleeding gums	Vomiting Spells
Motion/car sickness	**MUSCLE & JOINT:**	Stomach Aches
SKIN:	Spinal scoliosis	Abdominal Cramps
Change in mole(s)	Muscle weakness	Constipation
Hives / allergic reactions	Joint Pains	Diarrhea
Acne / skin eruptions	Painful tailbone	Jaundice
Itching (ears, skin, rectum)	Flat feet	Irritable Bowel syndrome
Bruising easily	**KIDNEYS/REPRODUCTIVE:**	**RESPIRATORY:**
Dryness	Inability to control urine	Asthma
Sensitive skin	Frequent urination	Wheezing
Eczema	Painful urination	Cough
Body odor	Bedwetting	Frequent colds
Hair loss	Kidney infection	**OTHER:**
	Bloody urine	

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

____

____

____

Thank you. We look forward to helping your family in any way we can.