RIVIERE
NATUROPATHIC HEALTH CLINIC

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Adolescent Intake Form (Ages 13-18)

We are aware of the time it takes to fill out such a lengthy intake form. However, your co-operation in completing it is essential to providing the highest standard of care. All information is confidential. PLEASE PRINT.

REGISTRATION

Today's Date _____

Child's Name _____
Parent's Name(s) _____Email _____
Age _____ Date of Birth _____ Gender: Male Female
Place of Birth _____ Ethnicity _____

Address _____
_____ Phone (___)_____

Emergency Contact _____ Relation _____
Phone (_____) _____

How did you find out about our clinic? ✓referral – Whom may we thank? _____
✓website
✓yellow pages
✓health food store
✓other _____

Other Health Care Providers

1. _____ 2. _____ 3. _____
_____ _____ _____
(___)_____ (___)_____ (__)_____

Health Concerns (in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Developmental History

Current Height _____ Current weight _____
Has your child reached all their developmental milestones?
Yes No Don't Know

MEDICAL HISTORY (please check all that apply to your child):
( ) Allergies (food, medication, environmental)
( ) Asthma
( ) Ear infections
( ) Frequent colds/sore throats
( ) Surgery For what?_____ When? _____
( ) Hospitalization For what?_____ When? _____
( ) Trauma (ie accidents, falls, fractured bones, sprains, etc) Explain
_____

Medications (past and current, include supplements):
_____ _____ _____
_____ _____ _____

Diet
Does your child have any food allergies/intolerances?
_____
_____
Does your child have any dietary restrictions (religious, vegetarian, vegan)?
_____
_____

Is your child a "picky" eater? Yes No Please explain.
_____

Typical daily diet:
Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____
Snack _____
Beverages (and total quantity) _____

IMMUNIZATION HISTORY (please indicate those your child has recieved and any reactions):

Vaccination	**Date Received**	**Adverse Reactions** (i.e. fever, rash, joint pain, fatigue, vomitting, seizures)
DPT (diptheria, pertussis and tetanus)		
Tetanus booster, when?		
MMR (measles, mumps, rubela)		
Haemophilus influenza B (HiB)		
"Flu"shot		
Polio		
Hepatitis A		
Hepatitis B		
Smallpox		
Chickenpox (Varivax)		

PRENATAL HISTORY:

Mother's age when child born _____Father's age when child born _____

How was each parent's overall health prior to pregnancy?
Mother _____
Father _____

Were there any complications during the pregnancy (trauma, emotional stress, high blood pressure, diabetes, weight gain, medications taken) ? Please explain.
_____

How was the labour and delivery? Were there any interventions (i.e. forceps, vaccuum, Cesarean section)?_____

Was your child born - before 38 weeks gestation? Yes No
- after 42 weeks gestation? Yes No

Child's weight at birth _____ Child's length at birth _____
How were your child's APGAR scores at birth, if known? _____

Was your child breastfed? Yes No
If Yes, for how long? _____
If No, what formula was your child given? _____

Was your child healthy during the neonatal period? Yes No
If No, please explain _____

At what age was solid food introduced? _____

FAMILY HISTORY (Please indicate if a close relative has had any of the following):
( ) Allergies Who? _____ ( ) Diabetes Who? _____
( ) Asthma Who? _____ ( ) Kidney disease Who? _____
( ) Cancer Who? _____ ( ) Heart disease Who? _____
( ) Depression Who? _____
( ) Other mental illness Who? _____
( ) Drug/Alcohol abuse Who? _____
( ) Don't know family medical history

GENERAL HISTORY
Check the symptoms/conditions which apply to your child:

✓**Generals**

_____ noticeable weight loss _____ fatigue _____ fever
_____ noticeable weight gain _____ weakness

✓**Skin**

_____ rashes _____ colour change _____ lumps
_____ changes in hair/nails _____ itching _____ dryness
_____ eczema _____ hives _____ psoriasis
_____ boils _____ moles

✓**Head**

_____ head injury _____ headaches
_____ hair loss _____ dandruff

✓**Eyes**

_____ redness	_____ spots	_____ pain
_____ specks	_____ excessive tearing	_____ flashing lights
_____ double vision	_____ blurred vision	_____ crossed eyes
_____ blind spot	_____ discharge	_____ bothered by sun

Do your child wear glasses/contacts? _____ Date of last eye exam? _____

✓**Ears**

_____ infection	_____ ringing in ears (tinnitus)	_____ vertigo
_____ discharge	_____ earaches	_____ hearing loss

✓**Nose and Sinuses**

_____ frequent colds	_____ hay fever	_____ nosebleeds
_____ nasal stuffiness	_____ discharge	_____ itching
_____ loss of smell	_____ sinus infections	

✓**Mouth and Throat**

_____ dry mouth	_____ bleeding gums	_____ tonsillitis
_____ sore tongue	_____ hoarseness	_____ stiff neck
_____ spots/sores in mouth	_____ dental cavities	_____ sore throat
_____ heat/cold intolerance	_____ lumps in neck	_____ loss of taste

Date of last dental exam? _____

✓**Respiratory**

_____ sputum	_____ cough	_____ bronchitis
_____ wheezing	_____ asthma	_____ pneumonia
_____ difficulty breathing	_____ chest pain	_____ pleurisy

✓**Cardiovascular**

_____ rapid heart beat	_____ slow heart beat
_____ high blood pressure	_____ heart murmurs
_____ low blood pressure	_____ rheumatic fever
_____ chest pain	_____ palpitations
_____ difficulty breathing	_____ blueness of skin (cyanosis)
_____ cold hands/feet	_____ leg cramps

✓**Gastrointestinal**

_____ trouble swallowing	_____ hemorrhoids
_____ constipation	_____ excessive hunger/thirst
_____ diarrhea	_____ poor appetite/thirst
_____ diabetes	_____ abdominal pain
_____ nausea	_____ food intolerance/allergy
_____ vomiting	_____ excessive belching
_____ regurgitation	_____ passing of gas
_____ vomiting of blood	_____ jaundice
_____ indigestion	_____ liver or gallbladder problems

Frequency of bowel movements? _____

✓**Genito-Urinary**

_____ dark-coloured urine	_____ blood in urine

_____ excessive urination
_____ burning/pain on urination
_____ pus in urine
_____ urgency
_____ incontinence
_____ frequency at night
_____ kidney infection
_____ foul smelling urine
_____ hesitancy
_____ urinary infections

✓**Musculoskeletal**

_____ muscle or joint pains
_____ back pain
_____ broken bones
_____ general muscle weakness
_____ stiffness
_____ artificial joints/limbs
_____ muscle spasms/cramps
_____ arthritis

✓**Neurological**

_____ fainting/blackouts
_____ insomnia
_____ nervousness
_____ difficulty concentrating
_____ loss of balance
_____ numbness/loss of sensation
_____ depression
_____ weakness
_____ irritability
_____ tension

✓**Hematological**

_____ anemia
_____ easy bleeding
_____ any past transfusions
_____ easy bruising

Any other conditions?

_____

Social History:
Does your child attend daycare or school? Yes No
If Yes, what grade/level are they in? _____

Does your child enjoy school? Yes No Don't Know
Please explain. _____

How is your child's social and academic performance (both in school and at home)?
_____

Does your child have any known learning disabilities? Yes No Don't Know
Has your child had developmental tests? Yes No

Has your child had their vision checked? Yes No Results
_____

How does your child interact with their peers or other children?
_____

Is your child involved in any extra-curricular activities, sports, hobbies?
Yes No Please explain. _____

What does your child enjoy doing on their spare time?
_____

How much television does your child watch, including video games?
( ) Less than 1 hour per day
( ) 1-4 hours per day
( ) More than 4 hours per day

How much sleep does your child get per night, on average? _____

Is your child exposed to any of the following on a regular basis?
( ) Second hand cigarette smoke
( ) Marijuana smoke
( ) Animals, what kind? _____
( ) Stress (emotional, physical)

Please rate the household stress level (0 = no stress, 10 = high stress)
0 1 2 3 4 5 6 7 8 9 10

Please add anything else you think is relevant to your child's medical history?
_____
_____

Note: *This page is to be filled out by the patient, and is strictly confidential.*

How would you rate your current health? (0 = really bad, 10 = the best it could be)
0 1 2 3 4 5 6 7 8 9 10

Do you enjoy school? Yes No Please explain. _____
_____

Are you involved in any clubs, hobbies, sports teams? Yes No
If Yes, what activities? _____

What do you enjoy doing on your spare time? _____

Do you exercise? Yes No If Yes, in what form and how many hours per week?
_____

How would you rate the stress level in your home? (0 = no stress, 10 = high stress)
0 1 2 3 4 5 6 7 8 9 10

Do you currently or have you ever done any of the following?
( ) Smoke cigarettes
( ) Use recreational drugs (i.e. marijuana, coccaine, ecstasy, acid)
( ) Drink alcohol

Are you currently sexually active? Yes No
If Yes, - What form of birth control do you use? _____
- Have you ever been tested for sexually transmitted diseases? Yes No

Female Patients:
Have you started menstruating? Yes No
If Yes, - At what age did your period start? _____
- How many days are your cycles (first day of bleed to first day of bleed) _____
- How many days is the flow? _____
- Do you have any other symptoms (i.e. cramps, back pain, tender breasts, moodiness)? Yes No Please explain.
_____
_____
- Have you ever been pregnant, had a miscarriage or abortion? Yes No