ADOLESCENT INTAKE FORM (AGES 13-17)

Child's Name: ____

Address: ____

City: ____________________ Province: ________ Postal Code: ____________

Phone (Home): ________________ Who is filling out this form? ________________

With whom does the child live? ____

Do you give Vive's doctors/staff permission to leave messages regarding your child's visits? yes❑ no❑

Male ❒ Female ❒ Age: __________ Date of Birth: ________________________

Emergency Contact: ______________ Phone: ____________ Relation: __________

Other health care practitioners the child is seeing (ie. Medical Doctor, Pediatrician, Chiropractor):

Name: ____________________ Phone: ______________________________

Name: ____________________ Phone: ______________________________

Name: ____________________ Phone: ______________________________

How did you hear about the clinic? ____

CONTEXT OF CARE REVIEW

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. The nature of your response for your child to the following questions will go a long way in assisting my understanding of your child's health and the most appropriate approach toward improvement. Your time, thoughtfulness and honesty in completing this overview will greatly aid my assisting your child's health needs.

What do you know about the naturopathic approach to medicine?

What expectations for your child do you have from this visit?

What long term expectations for your child do you have from working with the clinic?

Health Concerns

Please list your child's health concerns in order of importance:

1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________

Medical History

Was this child adopted? yes❑ no❑ If yes, at what age?________

List any injuries and/or major surgery your child has had and when they happened:

____
____
____
____

Has your child ever experienced any of the following?

- ❑ Rubella
- ❑ Mumps
- ❑ Measles
- ❑ Chickenpox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Diaper rash
- ❑ Cradle cap
- ❑ Diarrhea
- ❑ Constipation
- ❑ High fevers
- ❑ Bedwetting
- ❑ Strep throat
- ❑ Frequent colds
- ❑ Stomach aches
- ❑ Headaches
- ❑ Heat or cold intolerance
- ❑ Ear infections:
  How many? ________________
  How often? ________________
- ❑ Other illnesses/diseases:
  ____

Vaccinations (please check)

- ❑ DPT (Diptheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other: ________________

Did your child experience any adverse effects from vaccination? If yes, please explain:

____
____

Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list:

____
____
____

Does your child have any medical allergies or sensitivities? Please list:

____
____
____

Family History

Please indicate if any close relative *of the child* has any health condition(s) such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies, etc.

Relationship	Age	Health Condition(s)
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sister(s)		
Brother(s)		

THE FOLLOWING IS TO BE COMPLETED BY THE PATIENT

To offer you the very best in care, it is important to have a complete picture of your health. Please answer the following questions as completely and honestly as you can. The information you provide will be kept strictly confidential, unless it falls into a category that must be reported by law (i.e. alleged abuse, threat to self or others). If you have any concerns, please do not hesitate to discuss them at any time.

Sleep and Energy

What time do you usually go to bed? ________________ Wake in the morning? ____________________

Do you have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? ____

How would you rate your energy level on a scale of 1 to 10? ___________ (1 is low, 10 is high)

Diet and Exercise

Do you have any food allergies or intolerances? Please list. ______________________________________

____

Have you noticed any recent changes in your hunger or thirst? ____________________________

Do you suffer from acne? (please describe the acne, its location, the severity and frequency)

____

____

Do you think you weigh: ❑ too little ❑ too much ❑ about the right amount

Do you exercise? ❑ yes ❑ no

If yes, what form(s)? ____

How long? ___________________________________ How often? ______________________________

Have you ever or are you currently dieting? ❑ yes ❑ no

Have you ever used or are you currently using any diet aids? ❑ yes ❑ no

Do you consume soft drinks? ❑ yes ❑ no If yes, how many per day/week/month? ___________

Social

What grade level are you in at school? ______

Do you enjoy school? ❑ yes ❑ no

Why or why not? ____

What are your interests and favourite activities? ____

____

____

____

How many hours of television do you watch a day? ____________

How many hours do you spend on the computer? ____________

Do you smoke? ❑ yes ❑ no

If yes, when did you start? __________ How many cigarettes per day? _______

Have you ever experimented with alcohol or recreational drugs? (please elaborate) ____________

____

Have you received any information about any of the following? (if so, indicate the source – parents, friends, school, health care provider, other)

Physical or hormonal changes during puberty? ____

Sexual activity during puberty? ____

Birth control? ____

Sexually transmitted diseases and prevention? ____

Have you ever been, and are you currently sexually active? ❑ yes ❑ no

If so, did/do you use any type of protection against pregnancy and/or disease? ❑ yes ❑ no

If yes, what did you use? ____

Was the experience a positive one for you? ____

Is there any information on any of these topics that you would like provided to you? ____________

____

Questions for Females

Have you begun to menstruate? ❑ yes ❑ no If yes, at what age? ________

Is your cycle regular? ❑ yes ❑ no

How many days does your cycle last from the first day of menstrual blood to the day before your next menstrual blood? _____________

Describe the blood/flow (check all that apply):

❑ heavy ❑ dark red ❑ sticky
❑ moderate ❑ bright red ❑ clots
❑ light ❑ brown ❑ cramps
❑ other ____________________________

Is there any chance you are pregnant? ❑ yes ❑ no

Date of last menstrual period ______________________________

Have you noticed any changes to your breasts? ❑ yes ❑ no If yes, at what age? __________

Have you ever had your breasts examined? ❑ yes ❑ no

Have you ever been shown how to do a breast self-exam? ❑ yes ❑ no

If you have begun to menstruate, do you notice any changes to your breasts? ❑ yes ❑ no

If yes, before, during, or after your period? __________

Have you ever had a yeast infection or any other vaginal infection? ❑ yes ❑ no

Have you ever had a urinary tract or bladder infection? ❑ yes ❑ no

Do you ever suffer from vaginal or rectal itching? ❑ yes ❑ no

Can you describe any vaginal discharge you may have? (colour, consistency, odour) __________

____

Questions for Males

Have you noticed any changes to your penis or testes? ❑ yes ❑ no

If yes, when? ______________________________

Have you ever experienced any pain in your penis or testes? ❑ yes ❑ no

If yes, when? ______________________________

Have you ever experienced any sores or lesions on or around your genitals? ❑ yes ❑ no

Have you noticed any changes in growth of body, pubic or facial hair? ❑ yes ❑ no

Have you noticed any changes in your voice? ❑ yes ❑ no

Any history of urinary tract infection? ❑ yes ❑ no

Any difficulties in urination? ❑ yes ❑ no

Any discharge from the penis? ❑ yes ❑ no

Other Information

Is there any other information you would like to add about anything? __________

____

____

____

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: ______________________ Date: ______________________

This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to any person without your authorization.

DECLARATION AND CONSENT TO TREATMENT

Naturopathic Doctors minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or blood draws
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 24 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees.

Patient's Full Name: ____
First Middle Last

Date of Consent: ______________________________
Day Month Year

Naturopathic Doctor: __________________________

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Signature of Parent/Guardian