ADOLESCENT NATUROPATHIC INTAKE FORM

Name: ___________________________________ Sex: M F Date of Birth: ____________
Address____
City ______________________________State __________________ Zip Code ______________
Phone (Home) _______________ (Cell) ________________ (Parent's Cell) _______________
Okay to leave a message with parent? Y N Which number? ___________________
Parent/Guardian name(s): ____
Siblings (names & ages) ____

How were you referred to our office? ____
Other Health Care Practitioners
Name: ______________________________ Phone: __________ Fax: ________________
Name: ______________________________ Phone: __________ Fax: ________________

What is your chief health concern(s)?
1. ____
2. ____

Have the above condition(s) been diagnosed by a health practitioner? Y N
If Yes, when and by whom? ____

How would you describe your overall state of health?
Excellent Good Fair Poor

PAST MEDICAL HISTORY

Check with an [X] if you have now or in the past

Allergies		Asthma		Anemia		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Recurrent Colds	
Constipation		Cough		Diabetes		Diarrhea	
Easy bleeding		Easy bruising		Eating disorder		Eczema	
Emotional trauma		Eye infections		Fatigue		Fevers	
Fractures		Frequent urination		Fungal infections		Gas	
Hair loss		Hearing problems		IBS		Meningitis	
Mood changes		Migraine Headaches		Nausea		Nervousness	
Night sweats		Nose bleeds		Pneumonia		Physical trauma	
Seizures		Sleeping problems		Skin rash		Sore throat	
Stomach flu		Strep throat		Thyroid disorder		Tonsillitis	
Vision problems		Other					

If other, please describe: ____

Is there any condition from which you feel you have **never been well since?**
____

PERSONAL HEALTH HISTORY

Allergies: ____

Sensitivities (environmental/food): ____

Hospitalizations & Surgeries (reasons and dates): ________________________________

____

MEDICATION HISTORY

Please list all over-the-counter and prescription medications & supplements:

Medication/Supplement	Dose	Reason for Use

FAMILY HISTORY

Indicate with an [X] if anyone in your family has or has had any of the following conditions.

	Father	Mother	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)								
Health (G=good; P=poor)								
Anemia								
Asthma								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								

If other, please describe: ____

IMMUNIZATION HISTORY

Check with an [X] if you have had any of the following vaccinations.

Hepatitis A		HPV	
Hepatitis B		MMR/Rubella	
Tetanus		Varicella	
Polio		Meningococcal	

NUTRITIONAL HISTORY

Do you eat a healthy diet? Yes No

How would you describe your eating habits? ____

Food Aversions? Yes No Food cravings? Yes No

Any dietary restrictions? Yes No If yes, please explain: ____________________________________

Any concerns regarding weight or eating habits? Yes No

Please outline your typical daily food intake:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Water intake (ounces): _______ What source (tap, filtered, distilled, spring)? ________________

Other fluids: _____________________________________

Number of bowel movement daily? _______ Any difficulties? Yes No

LIFESTYLE HISTORY

Any recent major life changes? Yes No

Have you experienced any abuse (physical, emotional or sexual)? Yes No

Do you have a good support system? Yes No

How much stress do you experience in your life? mild moderate significant

Do you exercise regularly? Yes No

What type of exercise? ____

Do you have any hobbies or interests? Yes No

What type of hobbies/interests? ____

Are you a student? Yes No

SLEEP HISTORY

Does you sleep through the night? Yes No

Number of hours of sleep nightly? __________

Do you take any medication/supplement to help you sleep? Yes No

Do you wake up at all during the night? Yes No

Do you have bad dreams or nightmares? Yes No

SUBSTANCE USE

Have you ever used street, recreational, or IV drugs? ❑ Yes ❑ No

Do you smoke cigarettes? ❑ Yes ❑ No ❑ Not anymore If so, how many/how often? __________

Do you chew tobacco? ❑ Yes ❑ No ❑ Not anymore If so, how often? _____________

Do you use vape? ❑ Yes ❑ No ❑ Not anymore If so, how often? _____________

Do you drink alcohol? ❑ Yes ❑ No If so, how much/how often? ______________

REVIEW OF SYSTEMS
Check with an [X] whether you are having any of these symptoms NOW or OFTEN

Constitutional

No	Yes	
		Unexplained weight loss
		Unexplained weight gain
		Fever/chills
		Fatigue/lethargy/malaise

Cardiovascular

No	Yes	
		Chest pain
		Palpitations/Irregular heartbeat
		Syncope/fainting

Respiratory

No	Yes	
		Chronic cough
		Shortness of breath
		Difficult breathing on exertion
		Wheezing

Ears, Nose, Mouth, Throat

No	Yes	
		Hearing problem
		Frequent nosebleeds
		Tooth/Gum problem
		Frequent sore throat
		Ringing in the ear
		Earaches
		Sinus problems
		Mouth sores

Eyes

No	Yes	
		Eye itching or burning
		Eye discharge
		Eye pain
		Vision changes
		Glasses/Contacts

Skin/Breast

No	Yes	
		Rash
		Skin lesion
		Dry skin
		Breast lump
		Nipple discharge

Gastrointestinal

No	Yes	
		Abdominal pain
		Constipation
		Diarrhea
		Nausea/Vomiting
		Rectal bleeding
		Bloody stool

Genitourinary

No	Yes	
		Painful urination
		Leaking urine/Incontinence
		Frequent urination
		Abnormal vaginal bleeding
		Blood in urine
		Pelvic pain
		Female Only
		Vaginal discharge
		Painful cramps with period
		Bleeding/Spotting between periods
		Vulvar itching
		PMS

Neurologic

No	Yes	
		Headache
		Weakness
		Dizziness
		Seizures
		Numbness
		Migraines/Aura

Endocrine

No	Yes	
		Alopecia (hair loss)
		Cold or heat intolerance
		Excessive hunger or thirst
		Excessive urination

Musculoskeletal

No	Yes	
		Back pain
		Myalgias (muscle aches)
		Muscle weakness

REVIEW OF SYSTEMS (continued)
Check whether you are having any of these symptoms NOW or OFTEN

Hematologic/Lymphatic

No	Yes	
		Easy bruising
		Easy bleeding
		Cuts that do not stop bleeding

Allergic/Immunologic

No	Yes	
		Hay fever
		Hives/Urticaria

Psychiatric

No	Yes	
		Little interest in activities
		Feeling depressed/hopeless
		Feeling suicidal
		Anxiety
		Seeing a therapist/psychiatrist

SEXUAL HISTORY

No Intercourse Yet
Have you had sex with someone new in the last 90 days? Yes No
Do you have sex with: Men Women Both
Does the person you have sex with only have sex with you? Yes No Unknown
Is your sexual contact (check all that apply): Vaginal Oral Anal
Do you use condoms? Always Sometimes Never
Have you ever been exposed to a Sexually Transmitted Infection (STI)? No Yes
What is your birth control method ____

MENSTRUAL HISTORY (females only)

No Menses Yet
Age when periods started: _____
Periods come: less often than monthly monthly more often than monthly
Periods are: regular irregular (every month is different)
Periods last _____ days.
Bleeding is light moderate heavy
Have you ever been pregnant? Yes No

Thank you for taking the time to complete this detailed questionnaire. This information is kept confidential and will be a valuable resource as we work together to optimizing your health.