Adolescent Intake Form

(Ages 13-17)

Wild Heart
Therapies and Farmacy
Family Focused Naturopathic Care
561 M Highway 3 Fernie, BC
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Thank you for taking the time to complete the following new patient forms to the best of your ability. They are an important step towards defining your health care needs and achieving your health goals. Please email this form in advance for review, drop in off in advance, or bring this form to your first appointment. Please also include any relevant blood work or health reports.

All the answers on this form will be held ***absolutely confidential.***

Full Name (Last, First, Middle Initial): **Birthdate (dd/mm/yyyy):**

Address with P.O. Box:

City: **Prov:** **Postal Code:**

Phone (Home): **Phone (Cell):** **Phone (Work):**

Sex (please circle one): **Male/ Female/ Other/ Prefer Not to Say** **Height:** **Weight:**

Care Card #:

*** Guardian Information:**

Parent/ Legal Guardian #1

Name: **Phone #:**

Email:

Please check the box that applies ☑ **Joint Custody ☐** **Sole Custody ☐**

Parent/ Legal Guardian #2

Name: **Phone #:**

Contact Information if Different than Above:

Please check the box that applies ☑ **Joint Custody ☐** **Sole Custody ☐**

Preferred Method of Communication:

Other Children's Names and Ages:

Emergency Contact (Name, Relationship):

Phone # (if different than above):

Why did you choose to come to this clinic?

Have you seen a Naturopathic Doctor before? (Y/N)

Doctor Name:

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		
3		
4		
5		

ALLERGIES:

(Please list your allergy, your reaction and severity on a scale of 1-10)

Medications:

Food:

Environmental :

PAST MEDICAL HISTORY:

Have you ever been hospitalized? Y/N Why and which dates?

Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

Your birth history (prolonged labour, forceps, breastfed, etc.):

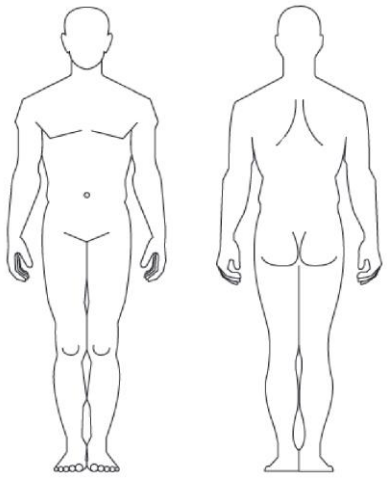
OCCUPATIONAL STRESS:

Chemical:

Physical:

Psychological/emotional:

PHYSICAL CONDITION:
(Please indicate on the diagram the nature of your symptoms using the provided symbols.)



Aching	**O**
Stabbing	**X**
Shooting	**=**
Burning	**~**
Numbness or Tingling	**^**

If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which you experience this pain:

_____

_____

Please describe your current physical condition (Truth please)**:**
Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity): _____

_____

FAMILY HEALTH HISTORY:			
RELATION	MEDICAL CONDITION	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Please mark conditions you previously or currently experience with P or C

P = past
C = current

GENERAL SYMPTOMS

- [ ] Loss of consciousness
- [ ] Numbness/tingling
- [ ] Fever
- [ ] Sweats
- [ ] Fainting
- [ ] Dizziness
- [ ] Loss of sleep/insomnia
- [ ] Frequent colds/flu
- [ ] Loss of weight

HEAD AND NECK

- [ ] Headaches
- [ ] Type
- [ ] Vision problems
- [ ] TMJ concerns
- [ ] Ear aches
- [ ] Decreased hearing
- [ ] Sinus problems

SKIN

- [ ] Rashes/eczema
- [ ] Itching
- [ ] Bruise easily
- [ ] Dryness
- [ ] Boils/hives
- [ ] Contagious skin disease

RESPIRATORY

- [ ] Chronic cough
- [ ] Shortness of breath
- [ ] Smoking
- [ ] Breathing problems
- [ ] Asthma/bronchitis

CARDIO VASCULAR

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Bleeding disorders
- [ ] Chest pain
- [ ] Stroke
- [ ] Artery hardening
- [ ] Varicose veins
- [ ] Swelling of the ankles
- [ ] Poor circulation
- [ ] Angina
- [ ] Heart disease

GENITOURINARY

- [ ] Trouble urinating
- [ ] Blood in urine
- [ ] Kidney infection
- [ ] Bed wetting
- [ ] Prostate trouble

GASTROINTESTINAL

- [ ] Poor digestion
- [ ] Indigestion
- [ ] Excessive hunger
- [ ] Belching or gas
- [ ] Nausea/vomiting
- [ ] Abdominal pain
- [ ] Constipation
- [ ] Diarrhea
- [ ] Hemorrhoids
- [ ] Liver concerns
- [ ] Gall bladder trouble
- [ ] Bladder concerns
- [ ] Ulcer
- [ ] Diabetes

INFECTIONS/ILLNESSES

- [ ] Herpes
- [ ] Hepatitis
- [ ] Plantar warts
- [ ] TB
- [ ] HIV/AIDs
- [ ] Cancer
- [ ] Allergies

MUSCLES & JOINTS

- [ ] Stiff neck
- [ ] Backache
- [ ] Swollen joints
- [ ] Painful tailbone
- [ ] Foot trouble L - R
- [ ] Shoulder pain L - R
- [ ] Elbow pain L - R
- [ ] Wrist pain L - R
- [ ] Hip pain L - R
- [ ] Knee pain L - R
- [ ] Arthritis
- [ ] Weakness/lost strength

WOMEN'S HEALTH

- [ ] Painful menstruation
- [ ] Excessive flow
- [ ] Irregular cycle
- [ ] Hot flushes
- [ ] Cramps or backache
- [ ] Vaginal discharge
- [ ] Swollen breasts
- [ ] Lumps in breast
- [ ] Are you pregnant
- [ ] Birth control
- [ ] Number of pregnancies
- [ ] Number of children

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SEXUAL HEALTH HISTORY:
Have you ever had or are you currently experiencing:

Had	Current		Had	Current		Had	Current	
☐	☐	**Chlamydia**	☐	☐	**Gonorrhea**	☐	☐	**Syphilis**
☐	☐	**Herpes**	☐	☐	**Yeast Infections**	☐	☐	**Bacterial Vaginosis**
☐	☐	**Hep B**	☐	☐	**Hep C**	☐	☐	**Scabies**
☐	☐	**Pubic Lice**	☐	☐	**Human Papillomavirus (HPV-warts)**			
☐	☐	**Trichomoniasis**	☐	☐	**Lymphogranuloma Venereum (LGV)**			

What kind of birth control do you use, if any?: _____

EXAM HISTORY:
(Please indicate when you most recently (if ever) had the following tests performed.)

Tuberculin (TB) test:	**Hearing Test:**
Chest X-ray:	**PAP or Gyne Exam:**
CT, MRI, Ultrasound:	**Prostate Exam:**
ECG (heart):	**Blood or Urine Tests:**
Eye Exam:	**Full Physical Exam:**

**Please report all medications on the medication history page, including vitamins/supplements.*

LIFESTYLE:
(Please describe a typical day's diet:)

Breakfast:	
Lunch:	
Dinner:	
Snacks:	**Beverages:**

How <u>MUCH</u> and <u>HOW OFTEN</u> do you consume:

Alcohol:	**Caffeine:**
Water:	**Tobacco:**
Recreational Drugs (which ones):	
Please list your travel history in the past 3 years:	

EMOTIONAL HEALTH:

(Please rate the following on a scale of 1 (low) to 10 (high))

Overall Stress: **Overall Energy:** **How happy are you generally:**

Stress in the Home: **Satisfaction in Relationship:**

Time to Bed: **Average Time of Waking:**

# of Hours of Uninterrupted Sleep: **Use of Sleep Aids (which ones?)**

Waking Feeling Rested (Y/N): **Digital Electronics in Bedroom (Y/N)**

Pets in the Bedroom (Y/N): **Co-Sleeping with Children:**

Have you ever felt sad or depressed for 2 weeks or more at a time in the past year: Y or N

Do you have concerns regarding your emotional or mental health (ie: anxiety, memory loss, voices, hallucinations, depression, binge eating etc)? :

SETTING THE STAGE:

What is your main expectation from this visit:

What long term expectations do you have:

What expectations do you have of me professionally:

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle: [1 (low) – 10 (high)]:

Are self destructive or negative lifestyle habits:

What potential obstacles do you foresee in addressing lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you:

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making:

What do you LOVE to do:

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Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS **Name: _____**

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
dd/mm/yyyy	Brand and Generic name (If available)		Quantity?	Route?	Frequency?	Food?			

Pharmacy:

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honour to take your child's care and health seriously. The following document is an agreement between the legal guardians of a pediatric patient and the doctor you see. This document states that you are entitled to understand any detail you wish about your child's health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits, and potential risks and side effects. Your child's health is ultimately up to your family; therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfil the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____The legal guardian of _____ as a patient of (Dr Name): _____ understand that my child is being treated under the pediatric practice philosophy and scope of naturopathic principles and practices, as regulated by the Canadian College of Naturopathic Physicians and the Health Professions Act of Canada. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my child's naturopathic doctor because I understand that care requires that I truthfully and completely disclose this information. I also will inform my child's naturopathic doctor if I am aware of any pre-existing medications or conditions, so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my child's diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable to my child. I am encouraged to take an active role in my child's care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my child's proposed treatment with their practitioner and that she has answered all of my questions to the best of her ability. I understand that should parental access change, it is the parents' responsibility to update the clinic with the most up to date separation agreement, parenting agreement, or court order notarized by a lawyer outlining the change of rights. Without this documentation, it will be assumed that both guardians have equal access to parenting rights and responsibilities even without equal parenting time.

I understand that though naturopathic treatments are generally safe, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals, and bruising or injury from acupuncture or intravenous therapies.

I understand that my child's naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue my child's treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for the cancellation of any appointments. I consent to email as a form of communication, and have provided the best email to do so with on my child's intake form. I acknowledge that some of the professionals that Naturopathic Doctors refer to are a part of unregulated professions in Canada, and that my ND will always disclose the nature of their referrals, the reason for their referral along with the benefits of seeing this practitioner (ie; Nutritionsists). I consent to appropriate interoffice verbal communication amongst practitioners when my child's ND feels it is appropriate and relative to the outcome of my child's care, if my child is being cared for by more than one practitioner in the clinic. My child's primary ND will be the only practitioner that has access to their chart unless I request otherwise. I am aware that I am always at liberty to seek and/or continue my child's care from another healthcare provider.

Signature (of patient, or legal guardian): _____
Date: _____
Witness: _____
Printed: _____