Dr. Michelle Mackay Patel, ND
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(780) 482-7617

NATUROPATHIC ADOLESCENT INTAKE FORM (13-17 years)

PERSONAL INFORMATION:

First Name(s): _____ Last Name: _____
Date of Birth (mm/dd/yy): ____/____/____ Age: _____ Gender: MALE / FEMALE
Current Weight: _____ Current Height: _____

Contacts:
1) Name: _____ Relationship: _____
Address: _____ City: _____ Province: _____
Postal Code: _____ Email: _____
Phone # (H): _____ (Cell): _____ (W): _____
2) Name: _____ Relationship: _____
Address: _____ City: _____ Province: _____
Postal Code: _____ Email: _____
Phone # (H): _____ (Cell): _____ (W): _____

Remind me of appointments by phone? (Please circle) YES / NO

Primary Care Provider (ie. Pediatrician, Medical Doctor): _____
Contact Information: _____
Please list other health care professional the patient is currently working with:
Practitioner Name: _____ Practitioner Type: _____ Phone: _____
Practitioner Name: _____ Practitioner Type: _____ Phone: _____
Practitioner Name: _____ Practitioner Type: _____ Phone: _____

HEALTH INFORMATION

Current **health concerns**, listed in order of preference:
1) _____ 3) _____
2) _____ 4) _____

How would you rate **overall health**? Poor Fair Average Good Excellent
How would you rate **overall energy**? Poor Fair Average Good Excellent

IMMUNIZATION HISTORY (please check)

Vaccine	Date	Adverse Reactions (e.g. fever, nausea, vomiting, seizures, behaviour changes,etc.)
☐ MMR (measles, mumps, rubella)		
☐ Polio		
☐ DPT (diphtheria, pertussis, tetanus)		

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☐ Influenza (Flu)		
☐ Smallpox		
☐ Haemophilus influenza B		
☐ Hepatitis B		
☐ Hepatitis A		
☐ Tetanus booster		
☐ Pneumococcal (pneumonia)		
☐ Meningococcal (meningitis)		
☐ Varicella (chicken pox)		
☐ Rotavirus		
☐ Other:		

CHILDHOOD ILLNESSES (please check)

	Date (s)	Comments
☐ Chicken pox		
☐ Measles		
☐ Mumps		
☐ Rubella		
☐ Scarlet fever		
☐ Pneumonia		
☐ Whooping cough		
☐ Rheumatic fever		
☐ Roseola		
☐ Bronchiolitis/Bronchitis		
☐ Strep throat		
☐ Ear infections		
☐ Mononucleosis		
☐ Impetigo		
☐ Other		

Surgeries and Hospitalizations (include dates and details): _____

_____

_____

MEDICATIONS:

Please list all current medications (prescription and over-the counter):

Medication	Dose/day	How long have you been taking?
1.		
2.		
3.		

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4.		
5.		

Please list all vitamins/minerals, herbs or homeopathics:

Supplement and Brand	Dose/day	How long have you been taking?
1.		
2.		
3.		
4.		
5.		

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

Have you ever had an adverse reaction to a medication? Y / N If Yes, please explain: _____

_____

ALLERGIES:

Please list all allergies (medications, seasonal, foods, animals etc.):

_____

_____

DIET

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

_____

_____

Do you have any dietary restrictions (religious, vegan/vegetarian, etc.)?

_____

_____

Describe a typical days diet:

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Beverages (including quantity) _____

SOCIAL HISTORY

Parents: Married:_____ Separated:_____ Divorced:_____ Single Parent:_____

Patient lives with:_____

Other's living in the home:_____

Mother's Occupation:_____ F/T or P/T

Father's Occupation:_____ F/T or P/T

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School

The patient is in: (circle) School Homecare Other: _____

On average how much time does the patient spend at school? _____

Describe the patient's behaviour and performance at school (include teacher comments and relationships with other children):

_____

_____

How many hours per day does the patient spend:	HRS
Watching Television	
Reading	
Playing Videogames	
Surfing the Internet	
Playing Outside	
Doing Homework	
Organized Sports/Lessons	

ENVIRONMENT

Describe your living environment (ex: house, apartment, new, old): _____

Is the patient exposed to any of the following (circle all that apply):

cigarette smoke pets mold chemicals (ex: paint)

How is the home heated?

- ☐ Natural Gas
- ☐ Oil
- ☐ Electric
- ☐ Wood
- ☐ Other: _____

How would you describe the emotional climate of your home?

_____

_____

FAMILY HISTORY

Please provide age and health concerns for the following biological family members. If deceased, please indicate the age of death.

Mother: _____

Father: _____

Siblings: _____

_____

Maternal Grandparents: _____

_____

Paternal Grandparents: _____

_____

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Please indicate if there is a family history of any of 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

Please **CHECK** if you are **currently** experiencing any of the following symptoms **OR** write a **"P"** if you experienced it in the past

GENERAL SYMPTOMS:

- ☐ Headache
- ☐ Head injury
- ☐ High fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Dizzy spells
- ☐ Fainting
- ☐ Excessive Fatigue
- ☐ Nervousness/Anxiety
- ☐ Loss of Weight
- ☐ Allergies
- ☐ Nightmares
- ☐ Sleep problems
- ☐ Cries easily
- ☐ Unusual fears
- ☐ Motion/car sickness

SKIN:

- ☐ Change in mole(s)
- ☐ Hives / allergic reactions
- ☐ Acne / skin eruptions
- ☐ Itching (ears, skin, rectum)
- ☐ Bruising easily
- ☐ Dryness
- ☐ Sensitive skin
- ☐ Eczema
- ☐ Body odor
- ☐ Hair loss

EARS/EYES/NOSE/THROAT:

- ☐ Tonsillitis
- ☐ Sore Throat
- ☐ Enlarged Glands
- ☐ Ear discharge
- ☐ Ear infections
- ☐ Mastoiditis
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Ear ache
- ☐ Nasal Discharge
- ☐ Nose bleeds
- ☐ Sensitivity to light
- ☐ Bad breath odor
- ☐ Canker sores
- ☐ Bleeding gums

MUSCLE & JOINT:

- ☐ Spinal scoliosis
- ☐ Muscle weakness
- ☐ Joint Pains
- ☐ Painful tailbone
- ☐ Flat feet

KIDNEYS/REPRODUCTIVE:

- ☐ Inability to control urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Bedwetting
- ☐ Kidney infection
- ☐ Bloody urine

CARDIOVASCULAR:

- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Irregular Heart Beat
- ☐ Bleeding gums
- ☐ Anemia

GASTROINTESTINAL:

- ☐ Bloating
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Reflux
- ☐ No appetite
- ☐ Belching
- ☐ Gas (flatulence)
- ☐ Nausea
- ☐ Vomiting Spells
- ☐ Stomach Aches
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Irritable Bowel syndrome

RESPIRATORY:

- ☐ Asthma
- ☐ Wheezing
- ☐ Cough
- ☐ Frequent colds

OTHER:

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

_____

_____

_____

Thank you for taking the time to fill out this form.
It will help contribute to a treatment protocol that will better your healthcare needs.