Adolescent Intake Form

Name_____ Today's date_____

Street_____ City_____ State_____ Zip_____

Phone number (_____)_____ Email_____

1. Blood Type _____
2. Height _____ Weight _____ Age _____
3. How would you rate your current state of health form 1-10. One being very low and 10 representing excellent health. _____
4. Have you had any medications within the last three days? Y/N (includes Tylenol, antihistamines, etc.), if yes please specify. Note any medications taken regularly or within the last three days:_____
5. **Drug/supplement (Name & What it is for)**: Dosage: Length of time taken:

6. Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Diagnosis	Frequency	Severity
e.g. Headaches	June 2007	July 2009	4 times per week	Mild / moderate / severe
1.				
2.				
3.				
4.				
5.				
6.				

7. Rate your emotional stress form 1-10; 1 representing hardly any:_____
8. What cravings do you have (if any):
   - ☐ Sweets and Starch
   - ☐ Salty & Greasy
   - ☐ Rich & Spicy
   - ☐ Dairy

   At what times of day (if specific and consistent):_____
   _____
9. Are there any foods that you avoid because they give you symptoms? Yes____ No_____

   If yes, please name the food and symptom e.g. wheat – gas and bloating:

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be?

_____

How many meals do you eat out per week (including cafeteria food? 0-1_____ 1-3____ 3-5____ >5_____

10. Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.? Yes _____ No _____ If yes, please explain:_____

11. Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?

Yes _____ No _____

12. Does skipping meals seem to have an effect on you? Yes _____ No _____
13. Do you have a noticeably sensitive gag reflex? Y/N

14. Do you find yourself gasping for air at times other than when exercising? Y/N

Check all symptoms and questions below that regularly occur. Mark "D" for daily "W" for weekly and "M" for monthly):

□ Get boils or sty's more than once per year
□ Throat infections more than once per year (sore throat
□ Cold sores, fever blisters more than once per year
□ Any infection with fever more than once per year
□ Swollen lymph glands more than once per year
□ Ear infections more than once per year
□ Slow to recover from cold or flu
□ Catch colds or flu easily
□ Lacerations (cuts become infected easily
□ Itchy or eyes
□ Itchy roof of mouth or throat
□ Swollen or itchy tongue or mouth
□ Difficulty in swallowing
□ Clear watery nasal Discharge
□ Mucous in the throat or congestion
□ Post nasal drip
□ Headaches
□ Discharge from the eyes
□ Puffiness under the eyes
□ Ear discharge or stuffed up
□ Wheezing
□ Sneezing
□ Fatigue
□ Exposed to cigarette smoke
□ Exposed to mold
□ Food allergies or sensitivities
□ Skin rashes
□ Entire body aches, painful to touch
□ Swollen joints
□ Certain foods make you sick, nauseous, depressed, jittery
□ Painful stomach or intestine
□ Alternating constipation and diarrhea
□ Hyperactivity
□ Fatigue increases after eating
□ Exposed to chemicals or radiation
□Eat luncheon meats containing nitrates or nitrites
□ Eat fruits and vegetables that contain pesticides
□ Eat foods that contain monosodium glutamate (MSG)
□ Use artificial sweeteners regularly
□ Milk produce symptoms
□ Pain in chest and/or arm
□ Calf muscles cramp
□ Heart palpitations
□ Feel jittery
□ Irregular heart beats
□ Swelling of feet and ankles
□ Fast heart beat
□ Exhaust with minor exertion
□ Light-headedness
□ General weakness
□ More than 3 cups of coffee/day
□ High daily stress level

□ Cold hands and feet
□ Tingling or burning in hands And/or feet
□ Numbness in extremities
□ Skin sores of the legs or feet
□ Spider veins on nose or face
□ Ringing in ears
□ Poor concentration
□Slurred speech
□Salt foods without tasting
□ Exercise regularly with low to moderate exertion
□ Exercise regularly with high exertion (Aerobics)
□ Vascular surgery
□ Chest pain without left arm pain
□ Tightness or pressure in the chest
□ Upper chest or neck itch
□ Chronic cough
□ Difficulty in breathing
□ Shortness of breath
□ 87. Sensitive to smog / air pollution
□ Infections settle in lungs
□ Respiratory attacks that last hours to days
□ Bleeding gums
□ Stomach pains after meals
□ Nausea
□ Dependency on antacids
□ Butterfly sensations in stomach
□ Difficulty in belching
□ Stomach pain when emotionally upset
□ Sudden, acute indigestion
□ Relief of stomach pain by drinking carbonated beverages
□ Relief of stomach pain by drinking cream or milk
□ History of ulcer or gastritis
□ Current ulcer or gastritis
□ Black stool while not taking iron supplements
□ Nervousness
□ White spots or lines on finger nails
□ Indigestion 1-3 hours after eating
□ Diarrhea
□ Roughage and fiber causes constipation
□ Do not eat high fiber foods daily
□ Less than 7 bowel movements per week
□ More than 2 bowel movements per day
□ Bowel movements are Irregular
□ Dark urine
□ Light colored stool
□ Hard stool
□ Shiny stool
□ Dark colored stool
□ Abdominal pain on right or left side
□Abdominal pain relieved by a bowel movement
□ Abdominal pain is triggered by eating
□Mucous in the stools
□ Stool poorly formed
□ Three or more large bowel movements daily
□ Foul smelling stool
□ Abdominal bloating
□ Intestinal gas
□ Dry skin or dry hair
□ Pain in left side of rib cage
□ Acne
□ Difficulty gaining weight
□ Dizziness when standing suddenly
□ Loss of vision when standing suddenly
□ Crave sweets
□ Crave carbohydrates
□ Headaches relieved by eating sweets or alcohol
□Impatient
□Moody
□ Irritable if a meal is missed
□ Wake up in middle of the night craving sweets
□ Wake up at night to urinate
□ Poor memory
□ Feel faint
□ Calmer after eating
□Frequent urination
□ Night sweats
□ Increased thirst
□ Lowered resistance to

wound infection
□ Leg sores
□ Poor wound healing
□ Feel energized from exercise
□ Failing eyesight
□ Crave sweets, but eating sweets does not relieve symptoms
□ Family history of diabetes
□Glucose (sugar in urine)
□ Elevated blood glucose (sugar)
□ Toe and fingernail fungus
□ History of antibiotic use
□ Anemic or recent history of anemia
□ Itchy skin
□ Itchy between toes and fingers
□ Chemical sensitivities
□ Depression
□ Bladder and kidney infections
□Yellowish conjunctiva (white part of the eyes)
□Pain radiates along outside of leg
□Intolerance to greasy foods
□ Headaches after eating
□ Gray colored skin
□ Pain in right side under ribs
□ Big toe painful
□ Don't eat regular balanced meals
□ Don't get enough to eat
□ More than 10 beers/week
□ More than 10 ounces of alcohol/week
□ Eat candy regularly
□ Drink soda pop regularly
□ Eat at fast food restaurants regularly
□ Eat fried foods regularly
□ Use refined sugars regularly
□ Diet often
□ Hair loss
□ Dry skin
□ Bones protrude
□ Don't use vitamins and minerals regularly
□ Use very large-doses of vitamins and/or minerals regularly
□ Neurological disorders
□ Sore or burning tongue
□ Lower back pains
□ Poor night vision
□ Confusion
□ Sore or sensitive gums
□ Leg pain or cramps
□Pain in feet
□ Some alcohol use regularly
□ High stress levels effect stomach
□ Lack of appetite
□ Dizziness
□ Inflamed corners of the mouth
□Steeply curved nails
□ Exposed to lead
□ Sensitivity to light
□Sensitive to the cold
□ Weight gain
□ Change in personality
□ Loss of temper or irritable
□ Enlarged neck
□ Trouble waking up in the morning
□ Low sex drive
□ Swollen (bulging eyes)
□ Warm, moist skin
□Tremors
□ Increased activity
□ Increased appetite
□ Weight loss
□ Insomnia
□ Diffuse tanning on exposed and unexposed portions of the body
□ Black freckles over the forehead, face, neck, and shoulders
□ Mood swings
□ Dark circles under the eyes
□ Slender fingers and extremities
□ Purple streak or line on the abdomen
□ Kidney stones
□ Osteoporosis
□Emotional disturbances
□ Inflammation in multiple joints
□ Stiffness lasting more than 30 minutes on arising in mornings
□ Stiffness lasting more than 30 minutes after prolonged activity

□Deformation of joints
□ Joints lock with movement
□ Early afternoon sleepiness
□ Skin nodules
□ Deep aching pain in bones, particularly the back
□ Vertebral fractures
□ Bone fractures
□ Pain in the extremities
□ Burning sensation in the extremities
□ Weakness in the extremities
□ Frequent tooth decay
□ Throbbing pain on one side or front and rear of head
□ Headache preceded by a short period of depression, irritability, or restlessness
□ Headache preceded by other visual disturbances
□ Visual disturbances disappear shortly after headache begins
□ Nausea associated with headache
□ Sensitive to light, especially during headache
□ Sensitive to noise, especially during headache
□ Extremities are cold before and during headache
□ Family history of migraine
□ Difficulty with speech before headache
□ Intensity of headache increases when lying down
□ Often prefer seclusion
□ Frequent urinary infections
□ Rarely need to urinate
□Urinate when you cough or sneeze
□Painful or burning urination
□Difficult urination's
□Dripping after urination
□Cannot hold urine
□ Rose colored (bloody urine
□ Cloudy urine
□ Strong smelling urine
□ Back or leg pains associated with dripping after urination
□ History of kidney or bladder infections
□ Back pain in the kidney area
□General water retention
□A sense of bladder fullness
□ Increased straining with smaller and smaller amounts of urine
□ Pain or fatigue in the legs or back
□ History of venereal disease
□ Yeast infections
□ Weight gain
□ Moodiness and irritability
□ Change in appetite
□ Suicidal feelings
□ Anxiety or anger
□ Respiratory allergies
□ Hot flashes
□ Sweating throughout the day
□ Dryness of skin, hair, etc.
□ Drug / Medication addiction
□ Must repeat actions constantly
□ Making decisions is difficult
□ Constant flow of speech

Informed Consent to Treatment:

As a parent seeking holistic care for my child, I understand that although all therapies are natural and non-invasive, there may be potential side effects and complications including, but not limited to: aggravation of current symptoms; sensitivities to ingredients in botanicals or supplements. I understand that I have my own rights to accept or reject any Naturopathic treatments offered.

I am clear of all charges and fees during the length of care and treatment and am responsible for paying them. I am also aware of the **24 hour cancellation** policy whereby if I shall not be able to make a scheduled appointment, I will phone the clinic to cancel my appointment and reschedule at my earliest availability so as to not interrupt the progress of my treatment. I am also aware that I will be charged for returned checks.

_____

Parent/Guardian Signature Date

Parent/Guardian printed full name:

_____