WOLFVILLE NATUROPATHIC CLINIC INC

Youth Intake Form (Ages 12-17)

Youth name_____ Age_____ Date & Place of Birth_____ Sex at birth_____
Full Address_____ Phone_____
Full name of Mother/Guardian _____ Occupation_____
Home Phone _____ Cell Phone _____ Email_____
Full name of Father/Guardian _____ Occupation_____
Home Phone _____ Cell Phone _____ Email_____
Please indicate any special living arrangements your child may have_____
Emergency Contact/Number_____ Emergency Contact/Number_____
Names of siblings & ages _____
Family Physician_____ Other Health Care Practitioners_____
How did you hear about this clinic?_____

Health Concerns (in order of importance)?

1. **2.** **3.**

4. **5.** **6.**

Medical History

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Current Medications and Dosages_____
Past Medications_____
Does this youth have any allergies?_____ To what?_____

Please circle which vaccinations this youth has had*:* *Tetanus Pertussis Diptheria Polio Measles Mumps Rubella Varicella Hepatitis B Influenza Meningitis Gardasil/HPV Other*_____
Please note any reactions to these vaccinations (fever, etc)_____

Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your child's age at the time:

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	

Please continue on the back of this page if you require additional space.

Family Medical History

Does anyone in this youth's family have a history of the following or other relevant conditions? Please use the back if necessary to describe:

Asthma/Allergies Cancer Diabetes Eczema/Psoriasis Kidney disease Autoimmune disease Anemia Anxiety/Depression

Development and Social Interaction

Was this youth delayed in reaching any of the following milestones (please circle)? *Holding head* *Smiling* *Rolling Over* *Sleeping through the night* *Sitting* *Crawling* *Speaking* *Walking* *Toilet Training* *Reading* *Writing*

Is this youth growing at an acceptable rate physically, mentally, and emotionally? (Explain)_____

_____

Has this youth ever been evaluated for (please circle) *Hearing* *Speech* *Language* *Other* Explain_____

How would you describe this youth's academic achievement?_____

How would you describe this youth's social interaction with peers?_____

Does this youth throw tantrums or have any destructive or odd interests which concern you? (Explain)_____

_____

Does this youth suffer from any of the following (please circle) *Nightmares* *Daydreaming* *Nervousness* *Moodiness* *Easy crying* *Separation anxiety* *Sleepwalking* *Hyperactivity* *Memory loss* *Fainting* *Seizures* *Unusual Fears*

Explain_____

Has this youth ever been a victim of mental, emotional, physical or sexual abuse?_____

Environment

Are there any pets in the child's home?_____ Does he/she have seasonal allergies? _____

Is he/she affected by any of the following? (Please circle) *Perfumes* *Molds* *Trees* *Grasses* *Weeds* *Molds* *Dust* *Animals*

Do your child live/sleep in a Basement?_____

Near a farm?_____ On a farm?_____

Approximately what year was your child's home/ dwelling built?_____ How is it heated?_____

Do you use chemicals on your lawn/garden?_____ What is your source of drinking water?_____

Is your child exposed to any chemicals/hazardous materials on a daily basis?_____

Can you think of anything in your child's home/school environment which might adversely affect his/her health (Explain)_____

_____

Life & Health- to be filled out by Youth or Parent/Guardian to best of knowledge

♦ **Youth Health- if applicable**

Have you ever been sexually active? Yes/No; Have you ever contracted a sexually transmitted disease? Yes/No? _____

What is your gender identity? (Circle) Male Female Transgender Male Transgender Female Gender Queer Other_____

What is your sexual orientation? (Circle) Straight Gay Lesbian Bisexual Other _____

Have you ever had psychiatric/psychological counseling? _____

♦ **Female Reproductive History (if applicable):**

Age of first menstrual period:_____ Is your period "regular"? _____

History PMS Symptoms (moodiness, cramps, breast tenderness, etc)? Explain_____

_____

♦ **Lifestyle**

Do you smoke?_____ Vape? _____ How often?_____ Have you ever used recreational drugs?_____

Do you drink alcohol?_____ How many drinks per day?_____ How many drinks per week?_____

Have you ever been treated for an addiction to drugs, alcohol, or prescription medications?_____

How many times per week do you exercise?_____ What form of exercise?_____

How many hours do you sleep per night_____ Do you have difficulty falling asleep?_____

How often do you wake through the night?_____ Do you awake in the morning feeling rested_____

On a scale of 1-10 (10 is highest) what is your energy like in the (a) *morning*_____ (b) *afternoon*_____ (c) *evening*_____

Please list the top three sources of stress in your life: 1)_____ 2)_____ 3)_____

Do you ever suffer from depression? (Explain)_____

Do you ever suffer from mood swings? (Explain)_____

How content are you with your life and what would you change _____

_____

What do you do in your leisure time?_____

Is there anything else that you feel I should know about you? (Please use the back of this page if necessary)