



ADOLESCENT INTAKE FORM (AGES 13 - 18)

Dear Parent and Patient,
Every detail you provide will help you achieve your health goals and will remain confidential. Please bring this completed form to your first appointment, along with any relevant blood work or health reports.

Patient's Name: _____ Height: _____ Weight: _____
Age: _____ Date of birth: _____ Gender: _____
Address: _____
_____ Home Tel: _____

PARENT/GUARDIAN CONTACT INFORMATION

Name: _____
Address: _____
Home Tel: _____ Work Tel: _____ Email: _____
What is the best way for us to contact you? _____
May we leave telephone messages at home or work? _____
Would you like to receive our clinic email newsletter? _____
How did you hear about this naturopathic medical practice? _____

Please circle the name of the Naturopathic Doctor you are seeking healthcare services from:

Dr. Sonya Nobbe

Dr. Christina Vlahopoulos

Dr. Jennifer Wheeler

Please list all other healthcare practitioners:

1. _____ 2. _____

() _____ () _____

Please list your primary concerns, in order of importance:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____



MEDICAL HISTORY

Please list hospitalizations, surgeries, traumas or major illnesses:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____
5. _____ Date of onset: _____

Please indicate which of the following immunizations you received:

- | | | | |
|------------------------------------|-------------|---------------------------------|-------------|
| <input type="checkbox"/> Polio | date: _____ | <input type="checkbox"/> Hep B | date: _____ |
| <input type="checkbox"/> MMR | date: _____ | <input type="checkbox"/> DTP | date: _____ |
| <input type="checkbox"/> Varicella | date: _____ | <input type="checkbox"/> Hib | date: _____ |
| <input type="checkbox"/> Hep A | date: _____ | <input type="checkbox"/> Other: | _____ |

Please describe any complications or reactions to the immunizations: _____

Please list any allergies or sensitivities you may have (e.g. to medications, food, scents):

Please list any medications or supplements (e.g. vitamins, herbs) you are **currently taking**:

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____
5. _____ Date started: _____ Dose: _____

Please list any medications or supplements you have taken **in the past**:

1. _____ Dose: _____ Start: _____ Finish: _____
2. _____ Dose: _____ Start: _____ Finish: _____
3. _____ Dose: _____ Start: _____ Finish: _____
4. _____ Dose: _____ Start: _____ Finish: _____
5. _____ Dose: _____ Start: _____ Finish: _____

On average, how many times have you been on antibiotics? _____



LIFESTYLE

Please describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much and how often do you consume the following:

Caffeine: _____ Water: _____ Tobacco: _____

Please describe what forms of exercise you participate in, and how often:

How many hours do you sleep each night? _____

How many times do you wake up in the middle of the night? _____

How often do you experience nightmares? _____

Please give a brief description of your daily routine (e.g. public school, wake/sleep schedule etc.):

Please briefly describe your travel history: _____

What (if any) pets reside in the home: _____

FAMILY HEALTH HISTORY

Please indicate whether the following health conditions **pertain to any of your family members**:

Condition	Relative	Age of Onset	Details
Heart or blood problems			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			



Digestion problems (e.g. Celiac disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Concerns about weight			
Mental illness (e.g. depression)			
Learning difficulties			
Difficulties with drugs and/or alcohol			
Other			

PRENATAL HISTORY - TO BE FILLED OUT BY PARENT OR GUARDIAN

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? _____

What medications (including supplements, herbs, recreational drugs or alcohol) did the mother take during pregnancy?

1. _____ Dose: _____ Reason: _____
2. _____ Dose: _____ Reason: _____

Did the mother experience any illness, traumas, or hospitalizations during her pregnancy?

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

BREASTFEEDING HISTORY

How long was your child breastfed? _____

Did any complications occur during this time? _____

At what age were solid foods introduced? _____

Did any complications occur with the introduction of solid foods? _____



SOCIAL HEALTH – TO BE FILLED OUT BY PARENT OR GUARDIAN

Does your child attend school? Yes No

If yes what grade are they in: _____

Does your child enjoy school? Yes No Don't know

Please explain: _____

How is your child's social and academic performance (both in school and at home)?

Does your child have any known learning disabilities? Yes No Don't know

Has your child had developmental tests? Yes No

Is your child involved in extra-curricular activities, sports or hobbies? Yes No

Please explain: _____

How much television does your child watch, including video games?

Less than 1 hour per day: _____ 1 - 4 hours per day: _____ More than 4 hours per day: _____

EMOTIONAL HEALTH – TO BE FILLED OUT BY PARENT OR GUARDIAN

Your child's home environment plays a significant role in their health and well-being. Please answer the following questions regarding your home and family situation. Your answers will remain confidential.

On a scale of 1 (low) to 10 (high), please rate your child's overall level of stress: _____

On a scale of 1 (low) to 10 (high), please rate your child's overall energy level: _____

How would you describe the emotional climate of your child's home? _____

Has your child suffered any emotional trauma (e.g. divorce, death, moving homes)?

Does anyone in the child's home or place of regular attendance smoke? _____

Is there any alcohol or drug use in the child's home? _____

Do you feel that your home is a safe place for your child? _____

Do you have any concerns regarding your child's emotional or mental health (please describe)? _

Is there anything else you would like to include on this form? _____

Thank you.



ADOLESCENT PORTION

Note: This page is to be filled out by the patient, and is strictly confidential. Please keep this page separate from the rest of the intake paperwork and bring it to your first appointment.

How would you rate your current health? (0 = really bad, 10 = the best it could be)

0 1 2 3 4 5 6 7 8 9 10

Do you enjoy school? Yes No

Please explain: _____

Are you involved in any clubs, hobbies, sports teams? Yes No

Please explain: _____

What do you enjoy doing in your spare time? _____

Do you exercise? Yes No

If yes, what form and how many hours per week: _____

How would you rate the stress level in your home? (0 = no stress, 10 = high stress)

0 1 2 3 4 5 6 7 8 9 10

Do you currently or have you ever done any of the following?

Smoke Cigarettes: _____ Use recreational drugs: _____ Drink Alcohol: _____

Are you currently sexually active? Yes No

If yes, what form(s) of birth control do you use: _____

Have you ever been tested for sexually transmitted diseases? Yes No

Female Patients:

Have you started menstruating? Yes No

If yes, at what age did your period start? _____

How many days are your cycles (first day of bleed to the first day of bleed): _____

How many days is the flow: _____

Do you have any other symptoms (i.e. cramps, back pain, tender breasts, moodiness): _____

Can any part(s) of this page be shared with your parent? Yes No

If yes, which part(s)? _____

Thank you.



INFORMED CONSENT FOR TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, counseling, and homeopathy. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60 to 120 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15 to 60 minutes each, according to your individual health requirements. The first consultation fee is generally \$150 to \$165 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at \$140 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of _____, understand that the form of medical care is based on naturopathic principles and practices. I will inform my naturopathic doctor of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform my naturopathic doctor if I am pregnant or breastfeeding.

I understand that I am entitled to know about my 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 courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, and bruising or injury from acupuncture.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

SIGNATURE

DATE

WITNESS



**CONSENT FOR COLLECTION, USE, AND DISCLOSURE
OF PERSONAL HEALTH INFORMATION**

Your health privacy is a primary concern and the personal health information you disclose to your Naturopathic Doctor during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the Board of Directors of Drugless Therapy – Naturopathy. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Naturopathic Doctor, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize _____, Doctor of Naturopathic Medicine, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

NAME

DATE

SIGNATURE

WITNESS