body of knowledge healing arts

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Teen Intake (ages 13-18)

PATIENT INFORMATION

Full Name: ______________________________ Date: ______________________

Date of Birth: ____________________ Gender: Male Female Ethnicity: ____________________
(Day/Month/Year)

Full Address (main residence):

____

____

PARENT / GUARDIAN'S CONTACT INFORMATION:

Full Name: ______________________________________

Relationship to child: ______________________________________

Telephone: (home) ____________________ (work) ____________________

(mobile) ____________________ Email: ____________________

Marital Status (circle): Single Married Divorced Separated Living with Partner Widowed

Other parent/guardian authorized to make decisions regarding this minor child (list/explain)?

If custody is shared, please indicate the child's living arrangements:

____

Emergency Contact: ______________________________ Relationship: ____________________

(_____)____________________ (_____)____________________ (____)____________________
Telephone - home Work Mobile / Pager

Does this child have any siblings? Y N

If yes, list age and gender: __________ __________ __________ __________ __________

Name of Medical Doctor: ______________________________________

Tel: (_____)______________________ Fax: (_____)______________________

Address: ____

Date of last visit to Medical Doctor: ____________________ Date of last physical: ______________

Is this child under the care of any other health care providers?

____
(name) (specialty) (contact)

____
(name) (specialty) (contact)

How did you hear of this clinic/who referred you? ______________________________

CONTEXT OF CARE (Note: If your child is a teen, please have them participate in answering the following questions.)

1. Why did you choose to bring your child to this clinic, and what do you know about our approach?

2. What <u>three</u> expectations do you have from your child's visit to our clinic?

3. What <u>long term</u> expectations do you have from working with us?

4. What is your present level of commitment to addressing any underlying causes of your child's signs and symptoms that relate to diet and lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

5. Please list the behaviors or lifestyle habits that your child or family currently engage in *regularly,* that you believe support your child's health:

6. What potential obstacles do you foresee in addressing the dietary and lifestyle factors which may be undermining your child's health?

7. Will the other members of your family *sincerely and consistently* support and participate in the lifestyle changes you will be making for your child?

8. What does your child LOVE to do?

MEDICAL HISTORY

Please list your child's **health concerns**. (Both yours and their own, if any.)

Concern	Since
1.	
2.	
3.	
4.	
5.	

What effect have these issues had on your child's life?

How would you describe your child's general state of health?

Please list any **major trauma, injury, or accident** (mental, emotional or physical) your child has sustained.

Incident	Date	Long-term effects

Please list any **surgical procedures** your child has undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that your child has received and describe their effectiveness.

CHILDHOOD ILLNESSES (circle all that apply & indicate the approximate dates):

Chicken pox | Measles | Mumps | Rheumatic Fever | Roseola

Polio | Scarlet fever | Tuberculosis | Whooping Cough | Impetigo

Ear Infections | Strep Throat | Mononucleosis | Rubella (German measles)

CHILDHOOD VACCINATIONS:
Please indicate which of the following vaccinations your child has received, and any side effects.

Vaccination	√	Date	Side Effects?
DPT (diptheria, pertussis, tetanus)			
Tetanus Booster			
MMR (measles, mumps, rubella)			
Haemophilus influenza B			
“Flu shot”			
Polio			
Hepatitis A			
Hepatitis B			
Varicella (chicken pox)			
Other			

MEDICATIONS / SUPPLEMENTS / OTHER SUBSTANCES
Please list all **current** medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug / Supplement (Company & Brand Name)	Used For	Date Started	Dosage / Frequency

How often has your child taken antibiotics? ______________________________
Date of most recent course of antibiotics? ______________________________

ALLERGIES, SENSITIVIES, EXPOSURES:
Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

Has your child ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays? If yes, please give details:

Has your child ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke? If yes, please give details:

Does your child have any sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? If so, please explain.

Has your child undergone any type of allergy testing? What kind? When? Results?

FAMILY HISTORY
Please indicate if any of your child's immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family Member(s)	Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism/ Drug use		Depression/ mental health		Kidney Disease	
Allergies / hay fever		Diabetes		Liver Disease	
Asthma		Eating Disorders		Overweight / obesity	
Arthritis		Heart Disease		Prostate Cancer	
Breast Cancer		High Blood Pressure		Other Cancer	
Colon Cancer		Hyper / hypothyroidism		Stroke	
Cystic Fibrosis		Inflammatory Bowel Disease		Other	

PERINATAL HEALTH HISTORY:

At what age did the mother of this child give birth?
Was this her first pregnancy? Y N If not, where is this child in the birth order?
Were there any difficulties in conceiving this child?

What, if any interventions were used to increase the chance of conception?

Please rate the mother's health out of 10 (10 being optimal health) at the time of conception: /10
Please rate the father's health out of 10 (10 being optimal health) at the time of conception: /10
Please describe any health problems, stress or complications, and the emotional state of the mother experienced during her pregnancy:

Did the mother use any of the following during pregnancy? If so, please list amounts/frequency.
Medications Y N
Tobacco (or 2nd hand) Y N
Alcohol Y N
Recreational drugs Y N
Exposure to workplace chemicals? Explain:

Mother's weight gain during pregnancy: ____________ Length of pregnancy: ________ weeks

Type of birth (circle): vaginal cesarean section Length of labour: ________ hours

Interventions (circle all that apply): forceps vacuum epidural episiotomy other?

Were there any complications during or immediately following labour and delivery?

For the mother: please describe your birthing experience.

INFANCY:
Birth weight: Birth length:

Any health concerns at birth?

In the first few weeks did your child experience any of the following (circle any that apply)?

Congenital birth defect fever feeding difficulties infection

Skin conditions jaundice restlessness colic constipation

Vomiting Other? ____

Age at first: sitting ____ crawling ____ teething ____ walking ____ talking ____

Any developmental delays or concerns?

DIETARY & LIFESTYLE FACTORS:

Was your child breastfed? Y N If so, for how long?

At what age did you introduce solid foods?
What order, if any, did you follow in introducing foods?

Did your child display any allergic-type, digestive, or skin reactions to any foods?

Height: Current Weight:
Concerns about height or weight?

Please be sure to have your teen fill out a diet diary and submit it with these forms.

Are there any foods you (or your child) exclude from your child's diet? For what reason?

Are there any foods that your child craves specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)
At what times?

How is your child's appetite?
How is your child's thirst?
How much water does your child drink daily?
What is the source of this water? (tap, bottled, filtered, well, etc)

What other beverages does your child drink, and how much?

How often does your child have a bowel movement?

What is the quality of your child's bowel movements? (hard/soft, colour, texture, etc)

How would you rate your child's energy level?
Their stress level?

Does your child exercise regularly? Y N
What forms of exercise?
What duration/frequency/intensity?

How much time does your child spend watching television / using a computer per day?
How much time does your child spend outdoors per day?

Is your child exposed to: ___pets ___smoke ___chemicals / fumes in the home or at school?

What are your child's interests / hobbies?

How does your child feel about school?

Describe your child's disposition:

How many hours of sleep does your child get per night? ______ hrs
What times does your child go to bed and awaken?
Any problems with sleep?

Does your child take naps? Y N For how long / when?

Does your child / family take part in any spiritual or religious activities? Please describe:

How would you describe the emotional climate of your home?

Please answer the following questions, and have your child fill out the accompanying confidential questionnaire for teens (aged 13-17) that follows.

Has your child been given any information about changes they can expect during puberty, their sexuality, birth control, or protection from sexually transmitted diseases?

Has your child been given any information about substances such as tobacco, recreational drugs, or alcohol?

Do you have any concerns or comments about any of these topics that I should be aware of?

ADDITIONAL
Is there any other information relevant to your child's health that has not been addressed?

CONFIDENTIAL QUESTIONNAIRE FOR TEENS (AGES 13-17):

Please Note: To offer you the very best in care, I need a complete picture of your health in all areas. Please answer the following questions as completely and honestly as you can. The information you provide will be kept strictly confidential, unless it falls into a category that must be reported by law. If you have any concerns, please do not hesitate to discuss them with me at any time.

Have you noticed any recent changes in your energy level, sleeping habits or behaviour?

Have you noticed any recent changes in your hunger or thirst?

Do you suffer from acne? (please describe the acne, its location, the severity and frequency)

Do you think you weigh: __ too little __too much __ about the right amount

Do you exercise?
What form (s)?
For how long, and how often?

Have you ever, or are you currently dieting?

Have you ever used, or are you currently using any diet aids? Which?

Please fill out the diet diary and submit it with these forms.

Do you consume soft drinks? Y N How many per day?

Do you smoke? Y N When did you start? How many cigarettes per day?

Have you ever experimented with alcohol or recreational drugs (please elaborate)?

Have you received any information about any of the following?
(if so, indicate the source - parents, friends, school, health care provider, other):

Physical or hormonal changes during puberty?

Birth control?

Sexually transmitted diseases and prevention?

Have you ever been, and are you currently sexually active?

If so, has the experience a positive one for you?

If so, did / do you use any type of protection against pregnancy and/or infections?
What type?

Is there any information on any of these topics that you would like provided to you?

Questions for Females:

Have you begun to menstruate?
If yes, at what age did menses start? Is your cycle regular?
How many days does your cycle last from the first day of menstrual blood to the day before your next menstrual blood?
How many days does your period (blood flow) last?
Describe the blood / flow: (heavy / moderate / light, dark red / bright red / brown, sticky, clotted/ cramps, etc?)

Is there any chance you are pregnant?

Date of last menstrual period?

Have you / when did you notice any changes to your breasts?

If you have begun to menstruate, do you notice any changes (PMS) the week or so before your period? (i.e. bloating, breast tenderness, cramps, mood changes, etc..)

Have you ever suffered from a yeast infection or any other vaginal infection?

Have you ever had a urinary tract or bladder infection?

Do you ever suffer from vaginal or rectal itching?

Can you describe any vaginal discharge you may have? (colour, consistency, odour)

Is there any other information you would like to add about anything?

Questions for Males

Have you / when did you notice any changes to your penis or testes?

Have you ever experienced any pain in your penis or testes?

Have you ever experienced any sores or lesions on or around your genitals?

Have you noticed any changes in growth of body, pubic or facial hair?

Have you noticed any changes in your voice?

Any history of urinary tract infection?

Any difficulties in urination?

Any discharge from the penis?

Is there any other information you would like to add about anything?