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TEEN INTAKE FORM – For Young Adults age 12 - 18

File Number: _____ Date _____

Last Name: _____ First/Middle Name: _____

Date of Birth: _____ Gender: Female Male
mm/dd/yy

Address: _____
Apt/House Number Street Name

_____ City Province Postal Code

Home Phone: _____ Cell Phone: _____

May we leave phone messages relating to your visits? YES NO

Email: _____

Parents/Guardians: _____
Name Relation Phone Number

Emergency Contact: _____
Name Relation Phone Number

Name of person completing intake form: _____

Care Co-ordination

Family Doctor: _____ Date of Last Visit: _____

Other Practitioners: _____

Have you been treated by a Naturopathic Doctor before? YES NO

If yes, by whom? _____ When? _____

How would you describe your general state of health? (circle one) excellent good fair poor

Health Concerns/History

What is the main reason for your visit? _____

How long have you experienced this? _____

Is it getting better or worse over time? _____

Please list your other health concerns or goals in order of importance

When did it start?	Concerns/Goals	What treatments have you tried?

Allergies and Sensitivities

Please list any known or suspected allergies, sensitivities, and/or intolerances to foods or drugs

Medications/Supplements

Please list all current medications and supplements including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Past Prescriptions

Please list past prescription medications

Injuries, Surgeries, Hospitalizations

Please list any past serious injuries, surgeries, and hospitalizations

Immunizations

MMR (Measles, Mumps, Rubella)		Polio		Hepatitis A	
DPT (Diphtheria, Pertussis, Tetanus)		Meningitis		Hepatitis B	
Haemophilus Influenza B (Hib)		Smallpox		Rabies	
Chicken Pox (Varicella Zoster)		Tetanus booster		Yellow Fever	
Typhoid		Other:		Other:	

Have you had adverse reactions to any vaccine? YES NO If yes, please explain: _____

Have you taken antibiotics within the past 5 years? YES NO If yes, how many times? _____

Past Medical History

Which of the following have you experienced? Indicate "C" for current, "P" for past or "F" for frequent:

Chicken Pox		Scarlet Fever		Tonsillitis	
Measles		Pneumonia		Ear Infections	
Mumps		Colds/Bronchitis		Sinus troubles	
Rubella		Rheumatic Fever		Allergies	
Asthma		Eczema/skin problems		Headaches	
Digestive problems		Colic		Constipation/Diarrhea	
Nausea/Vomiting		Growing pains/Scoliosis		Seizures	
Attention Problems		ADD/ADHD		Bed Wetting	

Do you use any of the following?

Alcohol		Laxatives		Tea	
Cigarettes		Antacids		Birth Control Pills	
Recreational Drugs		Diet Pills		Hormone Therapy	
Aspirin		Coffee		Other:	

Prenatal History

Were you premature? YES NO If yes, number of weeks? _____

Ultrasound during pregnancy? YES NO If yes, number of ultrasounds? _____

Medications during pregnancy? YES NO Medications during labour/delivery? YES NO

What type of delivery did you have? _____ Any complications during delivery? YES NO

Location of Birth: Hospital Birth Centre Home Weight at birth: _____

Were you breastfed? YES NO If yes, for how many months? _____

Or formula fed? YES NO If yes, type? _____

At what age were you introduced to solid foods? _____ To cow's milk? _____

Family History

Relative	Age	Health Problems	Died?	Cause
Mother				
Father				
Siblings (List)				
Grandmother (mom's mom)				
Grandfather (mom's dad)				
Grandmother (dad's mom)				
Grandfather (dad's dad)				
Other – specify (aunts, uncles, etc)				

General Information

Height _____ Weight _____

Have you lost or gained any weight in the last 6 months? YES NO If yes, how much? _____

Stress level at home (0 none, 10 extremely stressful): _____

Do you like school? YES NO Stress level at school (0 none, 10 extremely stressful): _____

What hobbies do you enjoy? _____

Physical Activity

Do you exercise? YES NO If yes, what type and how often? _____

After exercise, do you generally feel: Energized Happily Fatigued Tired Exhausted

Diet Type (non-vegetarian, vegetarian, vegan...) _____ How long? _____

Describe your typical daily diet

Breakfast: _____ Snacks: _____

Lunch: _____ Beverages: _____

Dinner: _____ Water: _____

Thank you!