PENINSULA
NATUROPATHIC CLINIC

YOUTH INTAKE FORM

Today's Date:_____

Name:_____ Gender: M/F Date of Birth:_____
Parents name(s) _____Phone #: (work)_____ (home)_____
MSP#_____
Address:_____
_____
How did you hear of us?_____
Emergency Contact (parent): Name:_____ Phone:_____

Diet:
Milk type/day_____Veg/d_____Fruit/d_____Grain/d_____Meat/d_____
Breakfast y/n Sweets/d_____ Fast food/wk_____
Allergies/concerns_____

Elimination: BM frequency_____ Concerns_____

Sleep: Hrs/night_____Nightmares y/n #/wk _____ Habits/concerns_____

School: Grade_____Where_____Days missed/mo_____Enjoys: y/n Doing well: y/n
Favorite subject_____ Concerns:_____

Other Health Care Providers

Name:_____ Type of Practitioner_____ Phone #_____
Name:_____ Type of Practitioner_____ Phone #_____
Name:_____ Type of Practitioner_____ Phone #_____

How would you describe your general state of health? ® Excellent ® Good ® Fair ® Poor

What are the current health concerns, in order of importance?

1. _____ How Long?_____ Prior treatment_____
2. _____ How Long?_____ Prior treatment_____
3. _____ How Long?_____ Prior treatment_____
4. _____ How Long?_____ Prior treatment_____

Current medications and natural medicines/supplements:_____
_____
_____
_____

Medical History

Major illnesses (describe):_____

® Allergies_____ ® Birth defects_____
® Asthma_____ ® Heart Disease_____
® Arthritis_____ ® Hypertension_____
® Cancer_____ ® Diabetes_____

Any previous hospitalizations or surgeries (describe)? _____
_____

Immunizations (recent) :_____
Any adverse reactions to the above immunizations (describe)?_____

How many times has child been treated with antibiotics?_____

Family History

Indicate if a close relative (parent, grandparent, sibling) has had any of the following.

® Allergies_____ ® Birth defects_____
® Asthma_____ ® Heart Disease_____
® Arthritis_____ ® Hypertension_____
® Cancer_____ ® Diabetes_____

Other comments?_____

Consent to treatment

Please read and sign.

I (parent's name)_____ give consent for treatment for (patient's name)_____ through Peninsula Naturopathic Clinic. I understand that in most cases it may take time to see improvements to my health and that follow up visits are essential to achieving long term health goals. Through commitment and personal responsibility to my health, naturopathic care will work to my benefit.

Effective naturopathic treatment may involve diagnostic testing, supplementation, herbal and homeopathic treatments, dietary and lifestyle changes. Acupuncture, craniosacral therapy, and body work are also offered and may be recommended. Treatment therapies recommended will be discussed amongst my naturopathic physician and me to reflect my personal health goals.

Signed (parent) _____ Date_____