TEEN INTAKE FORM

CYNDI GILBERT
NATUROPATHIC DOCTOR

PERSONAL & CONTACT INFORMATION

NAME: _____ ADDRESS: _____

GENDER: _____ ASSIGNED SEX: _____

PREFERRED PRONOUN: _____ PHONE: _____

DATE OF BIRTH (YY/MM/DD) _____ EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT ME?

OTHER HEALTH CARE PROVIDERS – *Please put a * beside the name of your primary health care provider*

NAME: _____ SPECIALTY: _____ PHONE: _____

NAME: _____ SPECIALTY: _____ PHONE: _____

HOW WOULD YOU DESCRIBE YOUR GENERAL STATE OF HEALTH?

EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR HEALTH?

1) 2) 3)

MAJOR TRAUMAS / SURGERIES / INJURIES / ILLNESSES – *Spiritual, mental, emotional, or physical*

EVENT	DATE	OUTCOME

ALLERGIES AND SENSITIVITIES – *List any known or suspected allergies, sensitivities and/or intolerances*

SUBSTANCE (FOOD, DRUG, ENVIRONMENTAL / CHEMICAL)	REACTION

CURRENT MEDICATIONS & SUPPLEMENTS – *Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, ...), birth control pills, herbs, vitamins, minerals, homeopathics, etc.*

NAME	DOSE	REASON FOR TAKING	DATE STARTED	SIDE EFFECTS

166 Montrose Ave., Toronto ON, M6J 2T8 • **T:** 416.817.2385 **F:** 416.536.5063 • cyndi@cyndigilbert.ca • www.cyndigilbert.ca

TEEN INTAKE FORM

CYNDI GILBERT
NATUROPATHIC DOCTOR

OTHER SUBSTANCES – *Which of the following have you used / do you currently use?*

	PAST OR CURRENT	AMOUNT	DATE STARTED	SIDE EFFECTS
ALCOHOL				
CAFFEINE/ ENERGY DRINKS				
RECREATIONAL DRUGS				
TOBACCO				

FAMILY HISTORY – *Please list if anyone in your biological family (parents, siblings, grandparents, aunts/uncles) has or has had any of the following. If you do not have information about your biological family's medical history, please skip.*

	FAMILY MEMBER		FAMILY MEMBER
ALCOHOLISM/DRUG ABUSE		DIGESTIVE CONDITION	
ALLERGIES/HAY FEVER		HEART DISEASE	
ARTHRITIS		MENTAL HEALTH CONDITION	
ASTHMA/EMPHYSEMA		OVERWEIGHT/OBESITY	
AUTO-IMMUNE CONDITION		SKIN DISEASE	
CANCER		THYROID DISEASE	
DIABETES		OTHER:	

SOCIAL HISTORY & LIFESTYLE

ARE YOU CURRENTLY IN SCHOOL? ☐ IF YES, WHAT KIND? PUBLIC ☐ PRIVATE ☐ HOME/ALTERNATE ☐

WHAT GRADE ARE YOU IN? _____ ARE YOU IN SPECIAL EDUCATION CLASSES? (E.G. GIFTED, AT RISK PROGRAM, ESL) _____

DO YOU ENJOY SCHOOL? YES ☐ NO ☐ WHY? _____

WHAT ARE YOUR FAVORITE SUBJECTS? _____

DO YOU PARTICIPATE IN ANY SPORTS, CLUBS, OR OTHER AFTER SCHOOL ACTIVITIES? _____

DIETARY RESTRICTIONS (E.G. RELIGIOUS, VEGETARIAN)? _____

DO YOU EXERCISE? IF YES, WHAT FORMS? _____ HOW OFTEN? _____

AVERAGE HOURS OF SLEEP / NIGHT? _____ IDEAL HOURS OF SLEEP / NIGHT? _____

DIFFICULTY FALLING/STAYING ASLEEP? YES ☐ NO ☐ WAKE RESTED? YES ☐ NO ☐

SEXUALITY: _____ RELATIONSHIP(S): _____

ARE YOU NOW, OR HAVE YOU EVER BEEN, SEXUALLY ACTIVE? ☐

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE AND HOW DO YOU COPE WITH THEM? _____