Teen Intake Form **Please circle all answers in BOLD**

History of Present Illness

Name/Preferred _____

Parents Names _____

Date_____/_____/_____ Age _____ DOB _____/_____/_____

Email address _____ Preferred Phone (____) _____-_____

Grade _____ Do you attend **School/Homeschool/College**

Do you have a job outside of home/school? **Yes/No** If yes, describe _____

_____

Please list your chief complaint _____

_____

How long have you had this symptom or problem _____ Does this concern interfere with **School/Work/Sleep/Daily Routine/Getting progressively worse**

Are symptoms **Constant/Intermittent**

Birth

Is there any history of birth complications such as prematurity, or congenital birth defects? **Yes/No** Please Describe _____

As an infant I was **Breast Fed/Formula Fed/Unsure,** and was **Vaccinated/Unvaccinated**

Pain

Do you have pain? **Yes/No** If yes, location _____ Please rate on the scale of 1-10 _____ Describe the quality of pain and does it radiate?_____

_____

Sleep

Do you sleep well? _____ How many hours? _____ Do you wake up at night? **Yes/No** If yes why? _____

Past Medical History

Has there been any medical diagnosis of your complaint? **Yes/No** If yes, list the diagnosis and who diagnosed you_____

_____

In the past I have tried **Acupuncture/Chiropractor/Diet/Emergency Room/ Exercise/Medications/Naturopathy/Routine Medical Care/Supplements/ Surgery/Other**

_____

How did this work? _____

What do you think is wrong? _____

Why do you feel your health is the way it is? _____

Please list any medical history/serious illnesses/hospitalizations/injuries? _____

_____

_____

For Teen Boys Only ☐ N/A

Do you perform monthly self testicular exams? **Yes/No**

Do you have any of the following currently or in the past?

Epididymitis/Hematocele/Hydrocele/Spermatocele/Spermatic Cord/ Testicular cancer/Testicular torsion/Varicocele/Trouble urinating/ Testicular Pain/Penile discharge/Burning with urination/

Are you Sexually active? **Yes/No** Number of partners? _____

STD treatments **Yes/No** If yes, which one _____

When? _____/_____/_____ Did symptoms resolve? **Yes/No**

For Teen Girls Only ☐ N/A

Age of first period _____ Are your periods **Regular/Irregular/Painful/ Symptomatic** If yes, describe _____ How many days is your flow? _____ days. What is your cycle length (i.e. every 28 days)? _____ days.

Do you check perform self breast exams monthly? **Yes/No**

Do you have any of the following currently or in the past **PMS/Cramps/Tender breasts/PCOS/Endometriosis/Breast cancer/Facial hair growth/Vaginal discharge/Yeast infections/UTI**

Are you Sexually active? **Yes/No** Number of partners? _____

STD treatments **Yes/No** If yes, which one _____

When? _____/_____/_____ Did symptoms resolve? **Yes/No**

Do you currently use contraception? **Yes/No** If yes which one? _____

What birth control have you used in the past? _____

Have you ever been pregnant? **Yes/No** If yes, number of pregnancies _____

Number of miscarriages _____ Number of induced abortions _____ Number of premature births _____ Number of term births _____ Birth weight of largest baby _____

Birth weight of smallest baby _____ In pregnancy, have you ever had **Toxemia (high blood pressure)/Gestational diabetes/ History of repetitive miscarriages/Other problems with pregnancy**_____

Health Maintenance

Date of last well exam with labs _____/_____/_____**Normal/Abnormal**

Do you get a flu vaccine annually? **Yes/No** Are vaccines up to date? **Yes/No** Explain: _____

_____

Family History

Mother's past medical history _____

Father's past medical history _____

Other pertinent family history _____

Allergies

Please list all allergies to medications, foods, or the environment _____

_____

_____

Medications

Please list any medications, supplements, or herbs that you currently take and for what conditions _____

_____

_____

_____

Toxic Exposure

Do you have mercury amalgam fillings? **Yes/No** If yes how many? _____
Do you have any artificial joints/implants? **Yes/No** If yes, where? _____
Have you, to your knowledge, been exposed to toxic metals such as **Lead/ Arsenic/Aluminum/Cadmium /Mercury/Oil Industry/Welding Industry/ Mechanic/Taxidermy/Other** _____
Was it treated? **Yes/No** If yes, describe _____
Do odors affect you? **Yes/No** If yes, which ones _____
Do you have **Running Water/Toilets/Well water/City water/Electricity**
If well water how many years? _____ In what state(s) was the well located? ____ Has the well water been tested for arsenic **Yes/No**
Have you ever lived in a basement for many years? **Yes/No** If yes, was this in an area of radon? **Yes/No** If yes, in what states _____

Social History

Do you have any hobbies or other leisurely activities? **Yes/No** If yes, please list _____

_____

Have you ever used alcohol? If yes, how often? **No longer drinking alcohol/Average 1-3 drinks per week/Average 4-6 drinks per week/Average 7-10 drinks per week/Average >10 drinks per week**
Have you ever had a problem with alcohol? **Yes/No** If yes, please indicate time period
From _____/_____/_____ to _____/_____/_____
Have you ever used tobacco? If yes, No. of years as a nicotine user _____
Amount per day _____ Year quit _____/_____/_____ If yes, what type(s) of nicotine have you used? **Cigarette/Vape/Cigar/Pipe/Patch/gum**
How many caffeinated beverages do you consume per day? _____
Have you ever been exposed to second hand smoke regularly? **Constantly/ Daily/ Weekly/ Monthly**
Do you use Marijuana? **Yes/No** If yes how is it ingested? **Smoke/Vape/Dab/Edible**
How often **Daily/Weekly/Monthly**
Do you use any other recreational drugs? **Yes/No** If yes, which one **Cocaine/Crack, Heroin/Meth/Prescription drugs/Other** _____
How often? **Daily/Weekly/Monthly**
Do you need of help with alcohol or recreational drug sobriety? **Yes/No**
How many hours of television do you watch per day? _____ Type pf television programs?

_____

How many hours in a day do you listen to talk radio, podcasts, or music? _____

Emotional Health

Are you happy in school, job, or current life work status? **Yes/No** If no why? _____

_____

How stressful is your life currently on a scale of 1 to 10, 10 being the most stressful? _____ For how long has your life been more than a 7 on the stress scale _____ What do you feel is the major cause of your stress?_____

_____

How do you cope with stress? _____ Have you ever been diagnosed with any of the following? **ADD/ADHD/Anxiety/Bipolar disorder/Depression/Eating disorder/OCD/ Schizophrenia/Other** _____

Do you ever feel **Fearful/Sad/Depressed thoughts**? **Never/Constantly/Daily/ Weekly/Monthly** Why? _____

Do you feel sad or down for no reason? **Never/Constantly/Daily/Weekly/ Monthly**

Do you feel worse at certain times of the year? **Yes/No** If yes **Summer/Fall/ Winter/ Spring**

How many hours in a week do you participate in activities you are passionate about? _____

Have you lost enthusiasm for your favorite activities? **Never/ Constantly/Daily/ Weekly/Monthly** Why? _____

How often do you feel that you have something that must be done? **Never/ Constantly/Daily/Weekly/Monthly** Why _____

Do you ever feel overwhelmed? **Never/Constantly/Daily/Weekly/Monthly** Why _____

_____

Do you ever feel paranoid? **Never/Constantly/Daily/Weekly/Monthly** Why? _____

_____

Overall do you feel you are an **Optimist/Pessimist/Neutral**

Do you ever have self-destructive thoughts **Never/Constantly/Daily/Weekly/Monthly**

Do you ever feel you have an inability to handle stress? **Never/Constantly/ Daily/ Weekly/Monthly** Why? _____

Do you prefer to isolate yourself from others? **Never/Constantly/Daily/Weekly/ Monthly** Why?

_____

Do you find it difficult to finish tasks? **Never/Constantly/Daily/ Weekly/Monthly**

Do you ever feel anxious or panicked for no reason? **Never/Constantly/Daily/ Weekly/ Monthly**

What do you think about yourself? **I love myself/I want to change myself to someone else/I hate myself/I don't like certain things about myself/I don't like anything about myself** The things that I don't like about myself are _____

_____

Is there anything hindering you from making self changes? _____

Growing up in life were you ever **Put down/Verbally abused/Physically abused/ Sexually Abused/Loved/Respected/ Encouraged me to do different things/Told me I would not amount to much /Pressured me to do things I did not want to do**

Spirituality

Do you feel you are an **Atheist/Agnostic/Religious/Spiritual**

Do you have a religious preference? If yes what? _____

Relationships

Do you have people/friends that you enjoy doing things with? If yes, **I have less than 2 close friends/2-5 close friends/5-10 close friends/10- 20 close friends/20-50 close friends/So many I cannot count** Of those friends or relatives are there any that you could turn to in a time of need? **Yes/No**

Home Life

Do you feel safe at home? **Yes/No** If no, why? _____
Is there any other place that you feel that you are unsafe? **Yes/No** If yes, please explain_____
_____
Are you **Homeless/Near homeless** What type of living situation do you live in? **Live with family/Live with others/Live alone**
What type of structure do you live in? **Owned home/Rented home/Rented Apartment/Cabin/RV/Car/Tent/None of the above/Other** _____
Guns present in the home? **Yes/No** Are they **Secured/Unsecured**

Mobility/Exercise

Do you have mobility limitations **Yes/No** If yes, Describe _____
What type(s) of exercise do you participate in **Baseball/Basketball/Boxing/ Kickboxing/Cardiovascular/Hiking/Martial arts/Pilates/Flexibility/Group exercise/Personal training/Snowshoeing /Skiing/Team Sports/Strength training/Tennis/Yoga/Tai Chi/Other**
_____
When you exercise, how long is each session? **15 minutes or less/16 to 30 minutes/31 to 45 minutes/46 to 60 minutes/61 to 90 minutes/more than 90 minutes**

Constitution

If you have something in the morning to drink what would it normally be? **Cold liquid/Hot liquid/Room temperature liquid**
If you have something to drink during the day what would it normally be? **Cold liquid/Hot liquid/Room temperature liquid**
If you have something to drink what would it most often be? **Tea/Coffee/Water/ Juice/Pop/Other** _____
If you are in a room with others and they are comfortable in regular clothing what are you wearing? **A coat/A short sleeve shirt/Wear what others have on**
At what temperature in the winter do you normally put on a coat to wear when you go outside? _____ degrees. At what temperature do you set your thermostat at home? _____ degrees
Do you consider yourself **Cold most of the time/Hot most of the time/Neutral temperature most of the time**

Digestion/Elimination

Height _____ Current weight _____ Weight six months ago _____ One year ago _____
Would you like your weight to be different? **Yes/No** If yes, how would you like it to be different? _____ Which of the following diet is closest to your own **Standard American Diet/Ovo-lacto vegetarian/**

Vegetarian/Vegan/Dairy restricted/Gluten Free/Diabetic/ Paleo/Autoimmune Paleo/Pescatarian/Flexitarian/Other _____

Do you have any of the following currently or in the past? **Constipation/ Diarrhea/IBS/ Gas/Bloating/Heart burn/Crohn's Disease/Ulcerative colitis/Diverticulosis/Celiac Disease/Gluten sensitivity/Food allergies/Food sensitivities/Leaky gut/Lactose intolerance/Gallstones/ Difficulty having a bowel movement/Upset stomach/ Nausea/Difficulty swallowing foods/ Foods stick in my throat/Foods taste bad/ Foods don't appeal to me.**

Do you have any food allergies or sensitivities to certain food? **Yes/No** If yes, please explain

_____

Do you have symptoms immediately after eating such as **Belching/Bloating/ Sneezing/Hives**. If yes, please name the food/supplement and the associated symptom

_____

Do you feel you have delayed symptoms such as **Fatigue/Muscle aches/ Congestion** after eating certain foods? If yes, which one (s) _____

Do you feel much worse when you eat a lot of **High fat foods/High protein foods/ High carbohydrate foods (breads, pastas, potatoes)/Refined sugar (junk food)/ Fried foods/1 or 2 alcoholic drinks/Other** _____ Does skipping a meal greatly affect you or your symptoms? **Yes/No**

Have you ever had a food that you craved or really "binged" on over a period of time? If yes, what food(s)? _____

Do you ever feel that you have lost control of what or how much you are eating? **Never/ Constantly/Daily/Weekly/Monthly**

Do you eat when you are **Stressed/Tired/Depressed/Bored/Upset/Happy/As a reward**

Are there certain foods that you strongly dislike? **Yes/No** If yes, which food(s) _____

_____

If you could change one thing about your diet to improve your health and wellness what would it be? _____

Are there any barriers to making this happen? **Yes/No** If yes, what? _____

_____

Do you eat breakfast? **Yes/No** If yes, describe your usual breakfast _____

_____

Describe your usual lunch _____

Describe your usual dinner _____

Do you snack? **Yes/No** Describe your usual snacks? _____

What do you usually drink during the day? _____

How much? _____

The healthiest three foods I eat during the week are _____

The worst three foods I eat during the week are _____

What percentage of your food is home cooked? _____%

Does your family **Cook/Hunt/Fish/Garden**

Did you know if you are unable to hunt or fish you can have someone proxy hunt or fish for you **Yes/No** Did you know you can also be added to the kill list **Yes/No** Where do you get the rest of your food from? _____

Describe the frequency of your bowel movements **More than 3X/day/1 to 3X/day/4 to 6X/week/2 to 3X/week/1 or fewer X/week/** This your **Normal/Abnormal**

Describe the consistency of your bowel movements **Soft and well-formed/Often float/Difficult to pass/Diarrhea/Thin, long or narrow/Small and hard/Loose but not watery/Alternating between hard and loose/watery** Describe the color of your bowel movements **Medium brown consistently/Very dark or black/Greenish color/Blood is visible/Dark brown consistently/Yellow, light brown/Greasy, shiny appearance/**
Other_____
How often do you have intestinal gas **Daily/Occasionally/Excessive/Present with pain/Foul smelling/Little odor**
How long have you had these symptoms? _____

Readiness to Change

Is there anything else you would like us to know? _____
Will family or others be supportive of your desire to make food and/or lifestyle changes? **Yes/No**
Are you willing to change what you believe about health and the body to improve your health? **Yes/No**

Goals

Please check the following things as personal goals:

- ☐ Get better grades
- ☐ Excel in sports
- ☐ To feel less sleepy in the afternoon
- ☐ Lose weight
- ☐ Increase my metabolism to burn more fat
- ☐ Increase my flexibility
- ☐ I want to reduce my stress
- ☐ I want to be able to be more focused
- ☐ I want a better mood
- ☐ I want to reduce my risk of developing a chronic disease
- ☐ I want to improve my diet
- ☐ I want to improve my skin
- ☐ Have more energy
- ☐ Sleep better
- ☐ Have better digestion
- ☐ Be able to eat more foods
- ☐ Get rid of my allergies
- ☐ Have a better immune system i.e. less colds and coughs
- ☐ Have better muscle tone
- ☐ Other: _____

Lastly, is it ok to leave a detailed message via phone or email? **Yes/No**
Kristen tries to make herself very available to her patients. Her personal cell is (907) 395-7565. If you contact Kristen via text on her personal cell phone please understand it is not secure. Kristen deletes texts and voicemails very quickly in an attempt to decrease this risk. Kristen will not answer medical qustions on social media. Please circle: **I understand and would like her cell number/I do not understand or do not agree, I will only contact Kristen through the office.**