NORTHERN SUN
FAMILY HEALTH CARE

TEEN INTAKE

Name_____ Preferred Name_____ Today's Date_____

Age_____ Date of Birth_____ Sex: _____SS# _____

Address_____

City_____ State_____ Zip_____

Telephone H: _____ Parent Cell:_____ Cell: _____

Mother/Guardian_____ Date of Birth_____

Occupation_____ Employer: _____

Father/Guardian_____Date of Birth_____

Occupation_____ Employer: _____

E-Mail Address_____ E-Mail Address_____

Emergency contact Name_____

Phone # _____ Address _____

How did you hear about Northern Sun?_____

What are your most important health concerns?_____

Are you currently receiving healthcare? Y N If so, with whom? _____

HEALTH HISTORY

Weight_____ Weight 1 year ago:_____ Maximum Weight:_____

Height:_____ Any decrease in height?_____ Maximum height: _____

When during the day is your energy best?_____ Worst? _____

MEDICATIONS

	Now	Past		Now	Past		Now	Past
Antidepressants	___	___	Antibiotics	___	___	Decongestants	___	___
Anti-anxiety Meds	___	___	Antihistamines	___	___	Steroids	___	___
Inhalers	___	___	Asthma Meds	___	___	Acne Meds	___	___
Pain Relievers	___	___	Sleep Meds	___	___			

Allergies to Medications_____

MEDICAL HISTORY

___ Chicken Pox ___ Headaches ___ Bronchitis ___ Tonsillitis, # of times ___

___ Measles ___ Pneumonia ___ Lyme disease ___ Ear Infections, # of times ___

___ Diabetes ___ Frequent Colds ___ Eczema ___ Asthma

___ Depression ___ Insomnia ___ Other _____

VACCINATION HISTORY

____ DTaP ____ Polio/IPV ____ HiB ____ Hep B ____ MMR ____ Varicella ____ Rotavirus ____ Pneumococcus

____ Flu ____ H1N1Flu ____ Gardisil/HPV_____ Any adverse reactions to immunizations? (Please specify): Y/ N

_____

X-RAYS, SPECIAL STUDIES, INJURIES, HOSPITALIZATIONS AND SURGERIES

When Where Results

_____

FAMILY HISTORY

___ Heart Disease ___ Diabetes ___ Birth Defects ___ Cancer ___ Mental Illness

___ Hypertension ___ Arthritis ___ Tuberculosis ___ Allergies ___ Hay Fever

___ Eczema ___ Psoriasis ___ Lyme disease ___ Autoimmune disease

SYMPTOMS

Please circle : Y = a condition you have now N = a condition you never had P= a condition you have had in the past

Hives	Y N P	Headaches	Y N P	Depression	Y N P
Eczema	Y N P	Frequent Urination	Y N P	Anxiety	Y N P
Bleeding gums	Y N P	Heart Murmur	Y N P	Nervous	Y N P
Nose Bleeds	Y N P	Vomiting Spells	Y N P	Sleep Problems	Y N P
Acne	Y N P	Anemia	Y N P	Night Sweats	Y N P
High Fevers	Y N P	Stomach Aches	Y N P	Sensitive to light	Y N P
Chronic Rashes	Y N P	Jaundice	Y N P	Body/Breath Odor	Y N P
Hearing Loss	Y N P	Easy Bruising	Y N P	Motion/car sickness	Y N P
Diarrhea	Y N P	UTI	Y N P	No Appetite	Y N P
Sore Throats	Y N P	Constipation	Y N P	Nightmares	Y N P
Dizziness	Y N P	Gas	Y N P	Canker Sores	Y N P
Frequent Colds	Y N P	Bleeding Tendency	Y N P	Unusual Fears	Y N P
Wheezing	Y N P	Joint Pains	Y N P	Excessive Fatigue	Y N P
Cough	Y N P	Respiratory Problems	Y N P	Hair Loss	Y N P

Any other condition not mentioned?_____

DIET

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Food Allergies/Intolerances_____

Coffee/caffeinated tea?	Y N P	Drink soda?	Y N P	Do you diet?	Y N P
Eat/crave sugar?	Y N P	Eat 3 meals a day?	Y N P	Eat out often?	Y N P

EMOTIONAL

Anxiety or nervousness	Y N P	Depression	Y N P	Mood Swings	Y N P
Suicidal thoughts/attempt	Y N P	Tension	Y N P	Treated for problems?	Y N P

HABITS

Alcohol or drug use?	Y N P	Treatment for addiction?	Y N P
Recreational drugs?	Y N P	Type and Frequency _____	
Tobacco?	Y N P	Amount and Frequency_____	
Screen Time?	Y N P	# Hours/day _____	
Use of seatbelt?	Y N P		

FEMALE REPRODUCTION

Age of first period?_____		Abnormal PAP	Y N P	Are/ were cycles regular?	Y N P
Bleeding between cycles	Y N P	Endometriosis	Y N P	Gardnerella infections	Y N P
Heavy/ Excessive/ Clots (circle one)		Length of cycle	Y N P	Ovarian cysts	Y N P
Painful menses	Y N P	Pelvic inflamm. disease	Y N P	Yeast infections	Y N P
PMS	Y N P	If yes, what are your symptoms? _____			

REPRODUCTIVE HISTORY

Number of pregnancies:_____	Number of abortions: _____	Number of births:_____
Number of miscarriages:_____	Difficulty Conceiving: Y N P	Birth control Y N P

Birth control type/ duration / satisfaction:_____
Children's names & ages _____

MALE REPRODUCTION

Birth control type_____				Discharge or sores	Y N P
Hernias	Y N P	Testicular masses	Y N P	Testicular pain	Y N P

SEXUAL HISTORY

Are you sexually active?	Y N P	Orientation_____		Chlamydia	Y N P
Gonorrhea	Y N P	Hepatitis A/B/C	Y N P	Herpes I /II	Y N P
History of abuse	Y N P	HIV	Y N P	HPV (Genital warts)	Y N P
Pain during intercourse	Y N P	Sexual difficulties	Y N P	Syphilis	Y N P

SLEEP

Sleep 7-8 hours/night	Y N P	Difficulty falling asleep	Y N P	Wake rested	Y N P
Wake often	Y N P	Difficulty getting back to sleep	Y N P	Nap	Y N P

EXERCISE/ACTIVITIES

What types of exercise/activities do you enjoy the most? _____
What are your current exercise habits/patterns? _____

PERSONAL/SOCIAL

Do you have a spiritual or religious practice?	Y N P	Do you have a community of support?	Y N P
Do you have supportive relationships?	Y N P	Any history of trauma or abuse?	Y N P

How does your condition affect you? _____

_____

What do you think is happening and why? _____

_____

What do you feel needs to happen for you to get better? _____

_____

What do you enjoy most about your life? _____

_____

How much change are you willing to make at this time to improve your health? Circle your choice below

MINIMAL SOME COMPLETE

We look forward to partnering with you in your quest for optimal health and well-being.

~ If you have any questions, please feel free to ask! Welcome to Northern Sun Family Health Care ~