NORTHERN SUN

FAMILY HEALTH CARE

SARAH ACKERLY, N.D., CPM **ALICIA THOMAS, N.D.** **LESLIE WALTER, CNM**

TEEN INTAKE

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: ____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Partnership ______

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	___	___	Anti-Histamines	___	___	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 = never had. P= have had in the past.

Hives	Y N P	Burning of Urine	Y N P	UTI	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 Rash	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	Flat Feet	Y N P	No Appetite	Y N P
Sore Throats	Y N P	Constipation	Y N P	Nightmares	Y N P
Headaches	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	Dizzy Spells	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

ENDOCRINE

Diabetes	Y N P	Excessive hunger	Y N P	Excessive thirst	Y N P
Fatigue	Y N P	Heat or cold intolerance	Y N P	Hypoglycemia	Y N P
Hypothyroid	Y N P	Seasonal Depression	Y	N	P

IMMUNE

Chemical sensitivity	Y N P	Chronic fatigue syndrome	Y N P	Chronic Infections	Y N P
Chronic swollen glands	Y N P	Reactions to vaccinations	Y N P	Slow wound healing	Y N P

NEUROLOGIC

Easily stressed	Y N P	Loss of balance	Y N P	Loss of memory	Y N P
Muscle weakness	Y N P	Numbness or tingling	Y N P	Paralysis	Y N P
Seizures	Y N P	Vertigo of weakness	Y	N	P

SKIN

Acne, boils	Y N P	Color change	Y N P	Eczema, hives	Y N P
Itching	Y N P	Lumps	Y N P	Night sweats	Y N P
Rashes	Y N P	Significant hair loss	Y N P		

HEAD

Headaches	Y N P	Head injury	Y N P	Jaw/ TMK problems	Y N P
Migraines	Y N P				

EYES

Blurry vision	Y N P	Cataracts	Y N P	Color blindness	Y N P
Double vision	Y N P	Eye pain/ strain	Y N P	Glasses or contacts	Y N P
Glaucoma	Y N P	Impaired vision	Y N P	Spots in eyes	Y N P

Tearing or dryness	Y N P				

NOSES AND SINUSES

Frequent colds	Y N P	Hayfever	Y N P	Loss of smell	Y N P
Nose bleeds	Y N P	Sinus problems	Y N P	Stuffiness	Y N P

MOUTH, THROAT, NECK

Copious saliva	Y N P	Dental cavities	Y N P	Frequent sore throats	Y N P
Goiter	Y N P	Gum disease	Y N P	Hoarseness	Y N P
Jaw clicks	Y N P	Lumps	Y N P	Pain or stiffness	Y N P
Sore tongue/ lips	Y N P	Swollen glands	Y N P	Teeth grinding	Y N P

RESPIRATORY

Asthma	Y N P	Bronchitis	Y N P	Cough	Y N P
Fainting	Y N P	Emphysema	Y N P	Pain on breathing	Y N P
Low blood pressure	Y N P	Pneumonia	Y N P	Shortness of breath	Y N P
pHLEBITIS	Y N P	Sputum production	Y N P	Wheezing	Y N P

CARDIOVASCULAR

Angina	Y N P	Blood clots	Y N P	Chest pain	Y N P
Fainting	Y N P	Heart disease	Y N P	High blood pressure	Y N P
Pleurisy	Y N P	Murmurs	Y N P	Palpitations/ fluttering	Y N P
Spitting up blood	Y N P	Rheumatic fevers	Y N P	Swelling in ankles	Y N P

GASTROINTESTINAL

Belching or passing gas	Y N P	Blood in stool	Y N P	How many bowel movements per day?	
Change in apetite	Y N P	Change in stools	Y N P	Change in thrist	Y N P
Heartburn	Y N P	Hemorrhoids	Y N P	Jaundice (yellow skin)	Y N P
Liver disease	Y N P	Nausea	Y N P	Pain or cramps	Y N P
Tarry/black stools	Y N P	Trouble swallowing	Y N P	Ulcer	Y N P
Vomiting	Y N P				

URINARY

Frequency at night	Y N P	Frequent infections	Y N P	Inability to hold urine	Y N P
Increased frequency	Y N P	Kidney stones	Y N P	Pain on urination	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

MALE REPRODUCTION

Birth control type________________				Discharge or sores	Y N P
Hernias	Y N P	Impotence	Y N P	Premature ejaculation	Y N P
Prostate disease	Y N P	Testicular masses	Y N P	Testicular pain	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 ____

BREAST:

Breast implants	Y N P	Breast lumps	Y N P	Breast pain/tenderness	Y N P
Breast redness	Y N P	Mammograms	Y N P	Nipple discharge	Y N P
Do you do self breast examinations?			Y N P		

BLOOD/ PERIPHERAL VASCULAR

Anemia	Y N P	Cold hands/feet	Y N P	Deep leg pain	Y N P
Easy bleeding/bruising	Y N P	Thrombophlebitis (clots)	Y N P	Varicose veins	Y N P

MUSCULOSKELETAL

Arthritis	Y N P	Broken bones	Y N P	Joint pain or stiffness	Y N P
Muscle spasms or cramps	Y N P	Sciatica	Y N P	Weakness	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	Type and Frequency ________________	
Use of seatbelt?	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 a supportive relationship?	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!