97 Charlotte St. Port Colborne, ON L3K3E2
155 HWY 20W Fonthill, On L0S 1E0
289-968-7395

Young Adult Intake Form

Last Name: ______________________First Name:______________________
Sex M ☐ F ☐ Age:________ Date of Birth (dd/mm/yyyy) ______________________
Child's Address:______________________Postal Code______________
Who is filling in this form (name, relation): ______________________

Contact Information:
Address: ______________________ City, Province: ______________
Postal Code: __________Primary Phone Number: __________Cell: __________

Emergency contact name:______________________Phone number:__________
Relation:____

Family Physician/ Pediatrician: ______________________________
Phone number: ______________________ Fax: ______________________
Permission to contact? Y / N
Date of last visit to MD: ______________________________

Have you been treated by an ND before? ______________________________
How did you hear about Lisa Maddalena, ND?______________________________

Current Health Assessment:

Please list your health concerns in order of importance and when they started:
1. ____
2. ____
3. ____
4 ____
5 ____

What treatments have been tried (both conventional and complementary) for the above concerns?
____
____
____

Please list any hospitalizations, surgeries, and/or major injuries you have experienced:

Description	Year

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Please list all current medications that you have taken including over-the-counter:

Medication name	Dose	How often	For how long	Reason

How many courses of antibiotics have you have taken: ____________________

Please list all supplements that you are currently taking:

Supplement name	Dose	How often	For how long	Reason

Please provide a rough outline of your daily eating habits:

Breakfast	
Lunch	
Dinner	
Snacks	
Water	
Other fluids	

Please indicate any allergies or sensitivities you have (food/environmental/ medication):

1.
2.
3.
4.

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Family History :

Please place a check beside conditions that apply to your immediate family:

Allergies		Arthritis		Asthma		Auto-immune disease	
Birth Defects		Bleeding Disorders		Cancer		Frequent urination	
Diabetes		Eczema		Heart Disease		Depression	
Hepatitis		Herpes		HIV/AIDS		Hypertension	
Kidney disease		Mental illness		Peptic ulcer		Thyroid disease	
Tuberculosis		Visual Problems		Speech Problems		Hearing Problems	

Other: ____

Reproductive Health:

Are you sexually active? Y / N For how long? __________
Do you use birth control? Y / N What type? ____

Female:
Have you begun menstruating? Y / N Age of first menses? _________ Are your cycles regular? Y / N
You ever had a PAP test? Y / N Have you had an abnormal PAP? Y / N

Review of Systems:

Which of the following apply to you? Please circle (Y) for current experience, or (P) for past:

Allergies	Y	P	Diarrhea	Y	P	Hair loss	Y	P
Asthma	Y	P	Ear infections	Y	P	Hearing problems	Y	P
Bed Wetting	Y	P	Eczema	Y	P	Lice	Y	P
Bladder infections	Y	P	Easy bleeding	Y	P	Measles	Y	P
Bloody urine	Y	P	Easy bruising	Y	P	Meningitis	Y	P
Burning urine	Y	P	Emotional trauma	Y	P	Mood changes	Y	P
Frequent urination	Y	P	Eye infections	Y	P	Mumps	Y	P
Chicken pox	Y	P	Fatigue	Y	P	Nausea	Y	P
Frequent colds	Y	P	Fractures	Y	P	Nervousness	Y	P
Cough	Y	P	Fever	Y	P	Night sweats	Y	P
Constipation	Y	P	Fungal infections	Y	P	Pneumonia	Y	P
Croup	Y	P	Gas	Y	P	Physical Trauma	Y	P
Cradle Cap	Y	P	Growing pains	Y	P	Rash	Y	P
Sinus infections	Y	P	Problems concentrating	Y	P	Developmental Delays	Y	p

Have you ever been well since? ____

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Miscellaneous:

Do you have trouble sleeping? Y / N Hours of sleep per night ________________________________
Do you nap during the day? Y / N

Do you exercise? Y / N Hours per week? _____ Types of exercise? _________________________
____

How would you rate your energy level from 1-10 (where 10 is the best you have ever felt)? _______

List the five most significant stressful events in your life:
1. ____ Date: ____________________
2. ____ Date: ____________________
3. ____ Date: ____________________
4. ____ Date: ____________________
5. ____ Date: ____________________
Are any of these events continuing to have an impact on your life? Y / N
(please indicate which number): __ Are you currently working with a professional counselor, psychologist, social worker, or other therapist? Y / N

Please indicate if you currently use any of the following, including how much and how often:

Tobacco		Alcohol	
Coffee		Laxatives	
Recreational Drugs (indicate type)			

Are you currently exposed to second hand smoke? ____

Do you enjoy school? Y / N
Do your heath concerns impact your performance in school Y / N

Have you traveled outside of the country in the past year? and where? ____________________________

Is there anything important that has not been covered in this questionnaire?
____
____
____

This is a confidential record of your medical history and will not be released to any individual without your authorization or legal requirement to do so.