

**MISSION NATUROPATHIC CLINIC**  
**202 – 2900 PANDOSY ST., KELOWNA, BC V1Y 1V9 (250) 862-8791**

Welcome to the office of Mission Naturopathic Clinic! We are honoured that you have chosen us in your search for optimal health. Please fill out and sign the attached forms to the best of your ability, and bring them to the initial appointment. It will aid in your assessment of your present health, and facilitate in your process of healing.

If you wish to cancel or reschedule you appointment; please do so **48 hours** or more before your appointment. We do reserve the right to **charge full cost** of the visit for missed appointments, or if insufficient time is given for cancellations. We will confirm your appointment 2 days prior to your visit by phone or leave a voice mail when necessary. If you are undergoing any treatments, please do not come on an empty stomach, as this may raise some of the risks associated with therapies. If you have any questions, please call our office at (250) 862-8791 or speak to the reception staff. We look forward to growing with you!

**Note:** many of our patient are sensitive to environmental substances; therefore, we ask that all patients refrain from wearing scented hairsprays, colognes, perfumes aftershaves, etc., on the day of your appointment.

**Payment Requirements:** Appointments must be paid for at the time of service. We accept VISA, MC, Debit, and cash.

**Records:** We keep a record of your health care services. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to. You can obtain copies of the files for a small fee upon signing an authorization form. Please allow up to 10 working days to process the request.

**Insurance:** Mission Naturopathic Clinic does not directly bill insurance companies. You may submit your paid invoice to your insurance company for reimbursement. We are also not a Government Funded healthcare provider, and no reimbursement will by honoured by this organization.

**I understand that I will have asked a Dr. Berg, Dr. Chambers, and/or Dr. Wolter of Mission Naturopathic Clinic for help and that she will help to the best of her ability.**

*I have read and understand the above statements.*

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Print Name

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Signature (signed by guardian if under-age)

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Date

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**Adolescent Intake Form**

Date: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: (M)\_\_\_\_/(D)\_\_\_\_/(Y)\_\_\_\_  
Last First Middle Initial

Personal Health Care Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Number: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Max weight: \_\_\_\_\_ When: \_\_\_\_\_

**Please list any Practitioners that you are currently seeing (conventional and/or alternative)**

Name:	Number:	How long:

<b>Please list your chief concerns in order of importance:</b>	<b>Onset:</b>	<b>Frequency:</b>	<b>Severity:</b>
<i>Example: Headaches</i>	<i>June '91</i>	<i>3 X week</i>	<i>Mild/mod/severe</i>
1.			
2.			
3.			
4.			
5.			

What are your goals for this visit? \_\_\_\_\_

Have you been given a diagnosis from other practitioners for any of these problems – if so what? \_\_\_\_\_

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Please fill in this form with any medication (prescription and non), vitamin, mineral, amino acid, or other supplements that you may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
<i>Example: Vitamin C</i>	<i>Natural Factors</i>	<i>Tablet</i>	<i>500mg</i>	<i>3 X day</i>

Comments: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Hospitalizations: \_\_\_\_\_

Surgeries (year and type): \_\_\_\_\_

Serious Illnesses/ Accidents/ Injuries (year, cause, and injury): \_\_\_\_\_

Have you ever used general anaesthetic?    Y        N        When? \_\_\_\_\_

Antibiotic use?        Y        N        When? \_\_\_\_\_

Allergies (type and onset)? \_\_\_\_\_

Pets (what kind and how many)? \_\_\_\_\_

**Childhood Illnesses:**

Health as a child: (1) Poor to (10) Excellent \_\_\_\_\_ Explanation: \_\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> German Measles | <input type="checkbox"/> Polio           |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Skin conditions |

**Vaccinations:** (please check all that apply)

- ( ) DPT (Diphtheria, Pertussis, Tetanus)
- ( ) Booster (usually DT)
- ( ) Polio injection    ( ) Polio oral
- ( ) MMR (Measles, Mumps, Rubella)
- ( ) HBV (Hepatitis B Vaccine)
- ( ) Other (flu shot, etc)

**Family History:**

Has anyone in your immediate family had any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Obesity        |

Other \_\_\_\_\_

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**School:**

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Favorite Subject: \_\_\_\_\_ Least Favorite: \_\_\_\_\_  
Do you enjoy school: Y / N Attention Span: long / short / bored easily  
Do you find school difficult: Y / N Challenging: Y / N

**Lifestyle:**

Types of food you eat (at least 4): \_\_\_\_\_  
Do you eat breakfast? Y / N How many meals do you eat in a day? \_\_\_\_\_  
What beverages do you drink (circle all)? water / juice / milk / pop / coffee / other  
Do you exercise or play sports? Y / N How often do you exercise? \_\_\_\_\_  
What types: \_\_\_\_\_  
How many hours of TV do you watch a week? 0-5 / 5-10 / 10-15 / 15-25 / 25+  
What type of TV shows/movies do you like? \_\_\_\_\_  
How many hours do you spend on the computer/internet per week? 0-5 / 5-10 / 10-20 / 20+  
What do you do for fun? \_\_\_\_\_  
Do you smoke cigarettes? Y / N Do you drink alcohol? Y / N  
Do you use recreational drugs? Y / N What types: \_\_\_\_\_

**Relationships (circle one):**

With father: Good / OK / Bad Explain: \_\_\_\_\_  
With mother: Good / OK / Bad Explain: \_\_\_\_\_  
With siblings: Good / OK / Bad Explain: \_\_\_\_\_  
With teacher: Good / OK / Bad Explain: \_\_\_\_\_  
With classmates: Good / OK / Bad Explain: \_\_\_\_\_

Are you currently in a relationship? Y / N Sexual preference? Male / Female  
Are you sexually active? Y / N For how long? \_\_\_\_\_  
Method of birth control (circle all applicable): Pill / Condoms / None / Other

Have you ever experienced abuse? Physically / Emotionally / Sexually  
Do you have someone you can confide in? Y / N

**Females:**

Have you had your menses? Y / N Age of first period: \_\_\_\_\_  
How many days to your cycle? \_\_\_\_\_ How many days of bleeding? \_\_\_\_\_  
Do you experience: cramps / bloating / menstrual irregularity / headache /  
increased appetite / moodiness / nausea / breast tenderness / fatigue  
Other: \_\_\_\_\_

History of pregnancy? Y / N Abortions: Y / N  
If female, have you had a PAP test before? Y / N

**Mood:**

Have you ever felt (circle all applicable): Sad / Depressed / Frustrated / Angry  
Explain: \_\_\_\_\_  
Energy level: Excellent / Good / OK / Poor / Exhausted  
How many hours of sleep do you get a night? \_\_\_\_\_  
Do you have difficulty falling asleep? Y / N Staying asleep? Y / N  
Do you feel stress in your life? Y / N What are your stressors? \_\_\_\_\_  
Any Further Comments or Concerns? \_\_\_\_\_