Dr* Andréa Proulx *ND, RAc

TEEN form (10-16 years old)

Welcome to your initial naturopathic consultation. Please take the time to fill out this form in order to give me background information needed to fully address all of your concerns. This will take approximately 20 minutes. You may also need info from parents or guardians.

Name: ___________________________________

Birthday: _____________________ year______

Gender: ___FEMALE________MALE ________

Address:________________________________
____
____
____

Tel #: _(____)__________________ Home
_(____)__________________ Cell

Emergency Contact Info:

Name___________________________________

Telephone #:_(_____)____________________

Contact relationship: _____________________

EMAIL TEL Preferred method of communication
YES NO May the clinic leave messages relating to your visits?
YES NO Can I send you my quarterly newsletter via email?
(Your contact information will Not be shared.)
YES NO Are you currently seeing another health care provider at this clinic?
If you are, who is it? _______________________________________

How did you hear about Dr Andréa Proulx, ND?: __internet____someone told me about her______

Members of your Health Care Team:

Medical Doctor
Name: _Dr.___________________________

Tel #: _(_____)__________________________

Address: _____________________________
____

Fax #: (_____)___________________________

Circle all that apply

Dentist Periodontist Other Dental

Massage therapist Physiotherapist

Personal trainer Coach Kinesiologist

Chiropractor Osteopath Pedorthist

Internist Rheumatologist Endocrinologist

ObGyn Midwife Counsellor

Dr **Andréa Proulx** ***ND, RAc***

Your Health Concerns *– What brings you to the clinic?*

Give a brief description of each of these concerns.

1)
2)
3)

Your Personal Medical History

Please write down any serious conditions, illnesses, injuries, and any hospitalizations:

Injury, condition, illness, hospitalization	*When did it happen? Take a close guess.*	*Do you still have this symptom?*	
		Yes	No
		Yes	No
		Yes	No
		Yes	No

Any allergies or sensitivities?

Allergies or Sensitivities			*What are your symptoms?*
Yes	No	Pollen: (types)	
Yes	No	Dust	
Yes	No	Animal dander: (types)	
Yes	No	Latex	
Yes	No	Food: (types)	
Yes	No	Other:	

CURRENT Medication / Supplement	Dosage/Brand	Prescribing Physician	Why are you taking this item?	Start date

Have you taken any other medications for more than 1 year that you did not list here? ____

Approximately how many times have you been treated with antibiotics? ___________________________

Where there any complications at birth?____

Have you had any of these illnesses?

Asthma	Chicken Pox	Mumps	Polio
Rheumatic Fever	Scarlet Fever	Roseola	Other: ____________________
Rubella (German Measles)	Whooping Cough	Measles	

Approximately how many times each year do you get colds or the flu? ____________

FAMILY SOCIAL HISTORY:
With whom do you live? ____
Have your parents lived together or divorced or separated? _____________________________________

INFO about your MOTHER – if applicable
Name:____ Age:__________________________
Occupation (if applicable): __________________________________
Is there anything unusual, or stressful about your relationship with this parent? If yes, please outline:
____

INFO about your FATHER – if applicable
Name:____ Age:__________________________
Occupation (if applicable): __________________________________
Is there anything unusual, or stressful about your relationship with this parent? If yes, please outline:
____

Do you have SIBLINGS?

Name of sibling	*Age*	*Gender*		*Lives*		*Quality of relationship*		
		F	*M*	*Home*	*Away*	*Poor*	*Average*	*Excellent*

Does ANYONE ELSE live with you?

Name	*Relationship*	*Quality of relationship*		
	Ex step-mom, foster child, friend	*Poor*	*Average*	*Excellent*

EDUCATION:
Current name of school: ____
Type of school: ______________________Grade:_________Teacher: _____________________________
Are you in any types of special education? Ex: ESL, gifted, at risk program_______________________
____
Do you enjoy school?________________ What are your favourite subjects?_______________________
Have there been any recent changes in your grades? If Yes, describe ___________________________

What is your **current stress level** on a scale of 1 to 10 (10 being the most stressed)? ______________
What is your **current energy level** on a scale of 1 to 10 (10 being the most energetic)? ____________

FOOD – What do you usually eat? List foods and beverages

Breakfast:____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages:____

Please indicate the amount of time you spend doing the following activities on a typical day:

Activity	Times (hrs)	Activity	Time (hrs)
Computer Related Work		Relaxing / Reading / Listening to music	
Watching Television / Gaming		Socializing / Time with friends	
Time spent outdoors		Organized time (lessons etc)	
Exercising or playing sports		Working (part time job)	

What type of organized **activities**, groups, **lessons** or **hobbies** do you have?
…..For example: sports teams, Scouts, church activities, outdoor activities, drama or music groups, school activities, crafts, **volunteeting** etc. ____
____

Do you smoke? Yes (How much per day _____) Never smoked
Do drink or take any caffeine? Yes No What kind, how much?________________________

Do you use or take any of the following? Aspirin Diet Pills Antacids Sleeping Pills
Laxatives Pain pills Recreational / street drugs

Do you have pets in your home? Yes No Type of pets? ____________________________

How many hours of sleep do you get per night? _____ Do you awake feeling rested? Yes No
What time do you go to bed of weekdays? _______ On weekends? _______

Family Medical History

Illness	*Circle*		*Family member*	*Comments (if needed)*
Alcoholism	Yes	No		
Anemia	Yes	No		
Arthritis	Yes	No		
Asthma	Yes	No		
Cancer	Yes	No		
Depression	Yes	No		
Drug abuse	Yes	No		
Diabetes	Yes	No		
Food allergies	Yes	No		
Digestive problems	Yes	No		
Stroke /Heart /Blood pressure issues	Yes	No		
Mental illness	Yes	No		
Thyroid disorders	Yes	No		
Other/ Family history unknown	Yes	No		

Do you experience any of the following?

Frequent antibiotics	Frequent colds/flus	Cold sores	Frequent sore throats
Concussion	Muscle weakness	Dizziness	Loss of balance
Numbness	Tingling	Loss of memory	Lack of coordination
Rashes	Itching	Eczema/psoriasis	Night sweats
Excessive sweating	Strong body odour	Acne	Hair loss or thinning hair
Headaches	Nose bleeds	Earaches	Teeth grinding
Dry eyes	Blurry vision	Ringing in ears	Cavities
Sores in mouth	Post nasal drip	Itchy ear canal	Mercury fillings
Excessive ear wax	Sinus infections	Difficulty breathing	Asthma
Shortness of breath	Throat phlegm	Chronic cough	Wheezing
Fainting	Irregular heartbeat / murmur		
Indigestion	Constipation	Bloating	Incomplete bowel movement
Gas or burping	Itching around rectum	Nausea	Stomach pains

How often do you have a bowel movement (poop)? ____

Urgency to urinate	Blood in urine	Pain on urination	Bladder infections
Neck pain	Muscle pain	Arthritis	Joint pain

Sexual Health History

How do you describe your sexual orientation?

Heterosexual Homosexual Bisexual Transidentified Questioning /Not sure

Are you now, or have you ever been sexually active? Yes No

If yes, what type of contraception / birth control did you use? __________________________

If yes, have you ever been treated for a sexually transmitted illness? Yes…. No

Female Patients

Have you started menstruating? Yes…. No

If yes, how old were you when you had your first period? ___________

Is your menstrual cycle regular? Yes…. No

How many days is your cycle (beginning bleeding to the next first day) ______

How many days do you have flow / bleeding? _______

Do you have any of these symptoms?

Clots during period	Food cravings	Sore breasts	Cramps
Bleeding between periods	Low back ache	Mood swings	Bloating
Heavy periods	Missed periods		

Are you currently pregnant? Yes…. No Have you ever been pregnant? Yes…… No

Mental/Emotional:

Sadness	Easily angered	Mood swings	Panic attacks
Anxiety/Nervousness	Depression	Irritability	Memory problems

Thank you.

Dr **Andréa Proulx** ***ND, RAc***

PRIVACY POLICY FORM

Privacy of your personal information is an important part of our Health Centre, while providing you with quality care. We understand the importance of protection your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

Consent Declaration
Dr Andréa Proulx ND understands the importance of protecting your personal information. To demonstrate our commitment to you, please find below an outline of how the office is using and disclosing your information.

This office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for all services offered by Dr Andréa Proulx ND.
- To collect fees relating to the services offered by Dr Andréa Proulx ND.
- To provide a means of communication between Dr Andréa Proulx ND and the Patient (via email or Canada Post mail) regarding services being offered at that time.
- To provide information on seminars and workshops offered by Dr Andréa Proulx ND via email or Canada Post mail.
- To provide handouts and additional relevant health information via email or Canada Post mail.
- To establish and maintain contact with you, including reminders of upcoming appointments.
- To assist this Health Centre to comply with all regulatory requirements and comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

DISCLOSURE:
1. to the Patient's/Client's doctor/health practitioner(s).
2. to colleagues of Andréa Proulx ND for the purposes of supporting Patient/Client health (all Patient/Client confidentiality is maintained).

We will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation and privacy protocols.

The privacy officer of this office is Dr Andréa. Proulx ND. A copy of the privacy policy is available on request.

Patient/Client Consent
I have reviewed the above information that explains how your Health Centre will use my personal information, and the steps your Health Centre is taking to protect my information.

______________________________ ______________________________ ______________________________
(Signature: parent or guardian) (PATIENT: Name) (Print name: Parent, Guardian)

______________________________ ______________________________
(Date) (Signature of Witness)

CONSENT TO TREATMENT FORM

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee.
I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print)

____

Date: __________________________________

Naturopathic Doctor: _Dr Andréa Proulx, ND. #1575

____

Signature of Patient (or Guardian):

____