Axiom Health

104-3040 TUTT STREET, Kelowna, BC V1Y 2H5

Welcome to the office of Dr. Alana Berg, ND and Dr. Audrey Wolter, ND, of Axiom Health 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 your 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 less than 24 hrs is given for cancellations. We will confirm your appointment 2 days prior to your visit by email reminder, please ensure you email is correct. 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 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: Axiom Health 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 be honoured by this organization.

I understand that I will have asked a Dr. Berg and Dr. Wolter of Axiom Health Clinic for help and that she will help to the best of her ability.

I have read and understand the above statements.

Print Name	Signature (signed by guardian if under-age)	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:

Please list your chief concerns in order of importance:	**Onset:**	**Frequency:**	**Severity:**
Example: Headaches	*June '91*	*3 X week*	*Mild/mod/severe*
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
Example: Vitamin C	*Natural Factors*	*Tablet*	*500mg*	*3 X day*

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: ________________

___ Rheumatic fever
___Allergies
___ Asthma
___ German Measles
___ Chicken pox
___ Ear infections
___ Polio
___ Mumps
___ Skin conditions

Vaccinations: (please check all that apply)

( ) DPTP (Diphtheria, Pertussis, Tetanus, Polio)
( ) Booster (usually DT)
( ) Chicken pox
( ) MMR (Measles, Mumps, Rubella)
( ) HBV (Hepatitis B Vaccine)
( ) Other (flu shot, etc)
( ) Meningococcal
( ) Pneumococcal
( ) H. Influenza B
( ) HPV
( ) Shingles

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

___Cancer
___Heart Disease
___Epilepsy
___Alcoholism
___High blood pressure
___Allergies
___Glaucoma
___Stroke
___Diabetes
___Arthritis
___Mental Illness
___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? ____

____