Axiom Health
202 – 2900 Pandosy St., Kelowna, BC V1Y 1V9

Welcome to the office of Dr. Alana Berg, 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 of Axiom Health Ciinic 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	___ German Measles	___ Polio
___Allergies	___ Chicken pox	___ Mumps
___ Asthma	___ Ear infections	___ Skin conditions

Vaccinations: (please check all that apply)

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

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Family History:

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

___Cancer	___High blood pressure	___Diabetes
___Heart Disease	___Allergies	___Arthritis
___Epilepsy	___Glaucoma	___Mental Illness
___Alcoholism	___Stroke	___Obesity

Other _____

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

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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? _____

_____