

IMI – Integrated Medicine Institute  
**ADOLESCENCES ADDENDUM (13- 18 yrs)**

To be filled out by patient between ages 13-18.

**Medical History:**

What are your health concerns, in order of importance?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Do you do/ take any of the following (check)?

- smoke, if so, how many packs per (circle) day / week \_\_\_\_\_
- alcohol, if so, how much and how often \_\_\_\_\_
- recreational drugs, if so, how much and how often \_\_\_\_\_
- others \_\_\_\_\_

**Psychosocial:**

How would you describe your

- relationship with parents:  Excellent     Good     OK     Poor
- relationship with siblings:  Excellent     Good     OK     Poor
- relationship with friends:  Excellent     Good     OK     Poor

Do you enjoy school? Yes / No

What do you like/ dislike about school?

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What is your stress level? Please rate on a scale of 1 (least) to 10 (most) for the following:

Home: \_\_\_\_\_ School: \_\_\_\_\_ Other (list): \_\_\_\_\_

List extra-curricular activities and hobbies: (sports teams, bands, piano lessons, etc.):

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List your goals (future goals, career, etc.):

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How much TV do you watch? (fill in # of hrs and circle day or week) \_\_\_\_\_ hrs a day / week

How often do you play video games? \_\_\_\_\_ hrs a day / week

How often do you use the internet/ computer? \_\_\_\_\_ hrs a day / week

Do you exercise? Yes / No If yes, what type of exercise, how much and how often:

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**MALE**

Age of onset of puberty: \_\_\_\_\_

Have you noticed any change in the penis and scrotum? \_\_\_\_\_

Are you familiar with normal growth patterns, nocturnal emissions ("wet dreams"), and sex education? \_\_\_\_\_

**FEMALE**

At what age did you notice your breasts were changing? \_\_\_\_\_

If you've gotten your period already, how old were you when you had your first period? \_\_\_\_\_

Average # of bleeding days (period) \_\_\_\_\_ Average # of days between bleeding \_\_\_\_\_

Is there bleeding between periods? \_\_\_\_\_

**Sexual History:**

Are you sexually active? Yes / No If yes, please continue.

What type of birth control do you use (circle)?

None/ Condom/ Birth Control Pill/ "Pulling out"/ Other: \_\_\_\_\_

Have you been tested for STD's/ venereal diseases? Yes / No If yes, which ones?

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Sexual Preference (circle): Heterosexual    Bisexual    Homosexual

Female: When was your last PAP test? \_\_\_\_\_

Female: Have you ever been pregnant, had a live birth, miscarriage or abortion?

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Is there anything you feel is important that has not been addressed?

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*Thank you for taking the time to complete this form.*