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Additional Section for Adolescents

This is a separate form to be filled out by the patient themselves.
The patient is to hand this form to the doctor directly.

Name: _____ Age: _____ Gender: _____

Date of Birth: _____

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N

How much sleep do you get on average per night: _____

What is your ideal amount of sleep per night: _____

Do you have trouble sleeping? Y / N

Do you ever experience anxiety? Y / N

Do you ever experience depression/ low mood? Y / N

Have you ever experiencing bullying at school?: Y / N

Are you happy with your school performance?: Y / N

Have you ever felt hurt, threatened, or been harmed in a relationship?: Y / N

Are you sexually active?: Y / N If Yes, are you a consenting participant? _____

What type of sexual practices do you engage in?

Do you practice safer sex?: Y / N

Do you use contraception?: Y / N, if Yes, what? _____

How often do you use or consume the following:

Coffee _____

Caffeinated Tea _____

Caffeinated Pop _____

Carbonated Beverages _____

Alcohol _____

Recreational Drugs _____

Cigarettes _____

Males

Do you experience testicular pain?: Y / N

Females

Have you started menstruating? Y / N, if Yes, at what age? _____

For how long do you bleed on average? _____ days Length of time between periods? _____ days

Do you experience irregular cycles?: Y / N

On average how many pads/ tampons do you use on the heaviest day of your cycle: _____

Do you experience any of the following during menstruation? (Please Circle)

Pain/ discomfort Breast tenderness Change in mood Headaches Cravings

Have you ever had a pelvic exam, including a PAP test? Y / N

Is there anything you would like to discuss with the doctor that hasn't been mentioned yet?

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