Tree of Life Medicine

Dr Gabriel Archdeacon & Kristin Renner

174 River St. • Montpelier, VT 05602 • 802 505 0597 • 802-223-2016 fax

PEDIATRIC INTAKE SUPPLEMENT (AGES 12-17)

Patient's Name _____ Today's Date _____

Date of Birth _____ Age _____

Please note: the question below should be filled out directly by the patient:

1. In the PAST YEAR, have you smoked cigarettes, vaped or use other tobacco products? Yes No

If yes, how often/how much? _____

2. In the PAST YEAR, have you have more than a few sips of beer, wine, or any drink containing alcohol? Yes No

If yes, how often/how much? _____

3. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than Half the days	Nearly every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Is there any information about yourself or your family that you would like to add?

_____

_____

_____

_____

_____