ADOLESCENT HEALTH HISTORY

Child's Name: ______________________ Date: ______________

Birthdate: ______________ Child's Age: ________ Sex: ❍ Male ❍ Female

Parent or Guardian's Name: ______________________

Address: ______________________ City / Town: ______________

Postal Code: ________ Home Phone: ____________ Other Number: ____________

Family Doctor's Name: ______________________ Clinic: ______________

Clinic Address: ______________________

Who may we thank for referring you? ______________________

Has your child ever recieved chiropractic care: ❍ Yes ❍ No Date of last visit: ______________

If yes, who was your child's previous Doctor of Chiropractic: ______________________

The reason for last visit: ______________________

PRESENT HEALTH CONCERNS (Please tell us about your reason for coming to our clinic)

Primary Concern: ______________________

____

____

Secondary Concern: ______________________

____

____

When did the problem begin? ______________________

Is this problem: ❍ frequent ❍ constant ❍ intermittent ❍ improving ❍ worsening

Does this problem radiate? ❍ Yes ❍ No If yes, where? ______________________

What makes this worse? ______________________

What makes this better? ______________________

Is the problem worse during certain times of the day? ❍ Yes ❍ No

If yes, when? ______________________

Does this interfere with sleep? ❍ Yes ❍ No Does this interfere with appetite / eating? ❍ Yes ❍ No

Does this interfere with daily routine? ❍ Yes ❍ No

Has another health care professional been seen for this condition? ❍ Yes ❍ No

Was there an treatment? ❍ Yes ❍ No Result of this treatment? ______________________

____

Recent tests (list date): ❍ Blood work ________ ❍ Urine ________ ❍ X-Rays ________

❍ Other ________

Does your child take any medications? What are the dosages? For what conditions? ________

____

Please indicate if any of the following are currently being experienced or have beem experienced in the last year:

❍headaches ❍dizziness ❍irritability ❍fatigue ❍depression ❍fainting ❍loss of concentration
❍poor coordination ❍loss of memory ❍light sensitivity ❍loss of balance ❍vision changes
❍loss of smell ❍loss of taste ❍difficulty breathing ❍shortness of breath ❍allergies ❍bronchitis
❍pneumonia ❍fevers ❍ears buzzing ❍ear pain/infections ❍asthma ❍sinus congestion
❍sore throats ❍frequent colds ❍reduced mobility ❍cold sweats ❍constipation ❍diarrhea
❍bloating/gas ❍urinary problems ❍weight loss ❍weight gain ❍food allergies/sensitivities
❍heartburn ❍dental problems ❍muscle cramps ❍upper back pain ❍neck pain ❍low back pain
❍radiating pain ❍sleeping problems ❍numbness in leg(s) ❍body stiffness ❍body awkwardness

What sports and activities does your child participate in? ________

________ How many hours per week? ________

Is their any history of sports or activity related injuries? ________

Describe: ________

____

Has your child ever been involved in any motor vehicle accidents? ________

When? ________

____

Does your child have any history of surgeries, hospitalizations, fractures, concussions, etc.? ________

____

What treatment was sought ________

____

Please note any health problems (IE cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers Family: ________

Fathers Family: ________

Siblings: ________

Is a school backpack used? ❍ Yes ❍ No Is it ❍ Heavy ❍ Light

Does your child take any vitamins or supplements? ______________________________

____

Does your child have any allergies or sensitivities? ______________________________

____

Does your child have any learning challenges? ❍ Yes ❍ No

If yes, what type: ______________________________

Does your child have: ❍ Night terrors ❍ Difficult sleeping ❍ Hyperactivity ❍ Restlessness

Other: ______________________________

Authorizing Consent for examination of a Minor (under 16 years): Please Read Carefully!

In order for the health professional as indicated below to make a determination on the suitability of my child's guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I have had the opportunity to discuss with the attending Doctor of Chiropractic about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

Patients Name: ____________________ Parent or Guardians name: ____________________

Date: ____________________ Signature(of guardian or parent): ____________________

Signature of Attending Chiropractor: ____________________