HEALTHY LIVING
Family Chiropractic

Patient# _____

Today's Date ____/____/_____

ADOLESCENT HEALTH HISTORY

(13 to 17 years)

We are excited that you have chosen Healthy Living Family Chiropractic to assist in your health and wellness needs!

Please fill out this form as completely as possible. Please print.

PERSONAL INFORMATION

Child's Name_____ What he/she prefers to be called_____

Home Address_____ City_____ State_____ Zip_____

Age_____ Date of Birth____/____/_____ Sex_____ SS#_____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION: *Primary Contact (for appointment reminders, etc.): □ Father □ Mother*

Father's Name_____ Mother's Name_____

Father's Cell Phone (_____) _____ Mother's Cell Phone (_____) _____

Father's Work Phone (_____) _____ Mother's Work Phone (_____) _____

Home Phone (_____) _____ E-mail _____

Parent's Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living Together

Preferred method of being reminded of appointments: □ Phone Call □ Text Message (no charge to you) □ E-mail

If text message reminders, we also need your cell phone carrier in order to send text: _____

REASONS FOR SEEKING CHIROPRACTIC CARE

At Healthy Living Family Chiropractic, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Please briefly describe the main concern that you would like Healthy Living Family Chiropractic to address for you.

_____

_____

Are these concerns affecting your quality of life? (Please check those applicable to you)

□ Work □ School □ Exercise/Sports □ Driving □ Walking □ Eating

□ Sleep □ Sitting □ Hobby – please list_____

When did the issue start? _____ What brought it on? _____

Have you had this problem before? □ No □ Yes – please explain _____

If you are experiencing pain, where is it located? _____

Describe the symptoms □ Sharp □ Dull □ Achy □ Numb □ Tingling □ Stabbing □ Throbbing

Does the pain travel/radiate anywhere? □ No □ Yes – please describe_____

Since the problem started, it is? □ About the same □ Getting better □ Getting worse

What makes it worse? □ Standing □ Walking □ Sitting □ Lying

□ Bending □ Lifting □ Twisting □ Coughing □ Other _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

Are you currently wearing □ Heel lift R/L □ Arch Supports

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for ***this condition***: □ Chiropractor □ Medical Doctor □ Other – please list_____

Name_____ City_____ Date_____

X-rays taken □ No □ Yes _____ Special tests done □ No □ Yes _____

Diagnosis_____ What was done_____

Have you ever had ***chiropractic care***? □ No □ Yes Name of D.C._____

How long under care? □ _____days □ _____weeks □ _____months □ _____years

Date of last visit_____ Why did you stop care? _____

Are you satisfied with the care you received there? □ No □ Yes

Have you consulted or do you ***regularly consult*** any of the following providers? (check all that apply)

□ Medical Physician □ Naturopath □ Acupuncturist □ Homeopath

□ Massage Therapist □ Psychotherapist □ Optometrist □ Dentist

YOUR HEALTH PROFILE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

GENERAL HISTORY

Please mark all symptoms you have ever had, even if they do not seem related to your current problem.

□ Dizziness	□ Leg problems	□ Fainting	□ Neck pain
□ Headache	□ Arm problems	□ Back aches	□ Loss of balance
□ Loss of smell	□ Poor posture	□ Scoliosis	□ Nervousness
□ Behavioral problems	□ Asthma	□ Poor appetite	□ Stomach upset
□ Fatigue	□ ADD/ADHD	□ Irritability	□ Tension
□ Sleeping problems	□ Stiff neck	□ Muscle pain	□ Growing pains
□ Diarrhea	□ Constipation	□ Fever	□ Bed wetting
□ Cold sweats	□ Lights bother eyes	□ Urinary problems	□ Heartburn
□ Mood swings	□ Menstrual irregularity	□ Menstrual pain	□ Ulcers
□ Trouble walking	□ Seizures	□ Diabetes	□ Cancer _____

Please list any other ***serious medical condition(s)*** you currently have or ever had:

_____

_____

PHYSICAL STRESS: CHILDHOOD THROUGH PRESENT

The minor and often ignored repetitive physical traumas that we have endured are often too numerous to list.

Have you ever been involved in ***organized sports*** (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, martial arts, etc.)? □ No □ Yes – please list _____

Have you ever been in a ***car accident***? □ No □ Yes – please explain _____

_____

Have you ever had a ***bone fracture or joint dislocation***? □ No □ Yes – please explain _____

_____

Have you ever ***hurt/injured*** your spine, head, neck, ribs, chest, upper and lower back, pelvis or hips? □ No □ Yes

If yes, state type of injury and date: _____

_____

Have you had any ***other traumas*** not described above? □ No □ Yes – please explain _____

_____

Have you ever been ***hospitalized***? □ No □ Yes – state reason and dates: _____

_____

Do you feel your ***book bag*** is too heavy for you to carry? □ No □ Yes

How many hours per day do you: □ Watch TV _____ □ Use a computer _____ □ Play video games _____

On average how many ***hours of sleep*** do you get per night? _____

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth or place on the skin (I.e. food allergies, drug reactions, exposure to chemicals in the air, etc.).

Please answer the following which will reveal exposures you may have had.

Were you ***vaccinated***? □ No □ Yes If yes, did you have a ***reaction***? □ No □ Yes

Have you been exposed to any of the following on a regular basis (past or present)?

□ Toxic chemicals □ Second hand smoke □ Drug therapy □ Radiation □ Chemotherapy □ Other_____

Do you have any ***food/drink allergies, sensitivities or intolerances***? □ No □ Yes – please list:

_____

Do you presently ***consume*** any of the following? □ Caffeine □ Tobacco □ Over the counter drugs □ Prescribed drugs

Please list any ***drugs or medications*** (prescription or over-the-counter) you are taking and the reason why.

_____

_____

Please list any ***vitamins, supplements, herbs, homeopathics, etc.*** that you are taking and the reason why.

_____

_____

Note: it is imperative that you list all medications as they may have an influence on your care.

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.

Please indicate if you have experienced any of the emotional stresses below. (check all that apply)

□ Childhood trauma □ Loss of loved one □ Abuse □ Work □ School

□ Parents Divorce □ Illness □ Self-esteem □ Other _____

Do you have ***difficulty concentrating***? □ No □ Yes – please explain: _____

Do you feel ***overwhelmed or frustrated***? □ No □ Yes – please explain: _____

Do you get ***angry easily***? □ No □ Yes – please explain: _____

FAMILY HISTORY

Mother: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems

□ Kidney □ Stroke □ Cancer _____ □ Other _____

Father: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems

□ Kidney □ Stroke □ Cancer _____ □ Other _____

Siblings: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems

□ Kidney □ Stroke □ Cancer _____ □ Other _____

ADDITIONAL QUESTIONS

If there is a need for ***dietary changes or nutrients***, would you like to be informed? □ Yes □ No

If there is a need for ***specific exercises***, would you like to be informed? □ Yes □ No

If there is a need for support in the ***emotional/stress area of health***, would you like to be informed? □ Yes □ No

Is there any ***specific health topic*** you would like more information on? _____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (check all that apply)

□ Relief of a symptom or problem

□ Relief and Prevention of a symptom or problem

□ Healthier spine and nerve system

□ Best possible health on all levels

PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give the doctors of Healthy Living Family Chiropractic permission to administer care to my son/daughter as they deem necessary. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Parent Name_____ Signature _____ Date ____/____/_____

Thank you for choosing our practice! We look forward to helping you.