



Chiropractic Adolescent Health Questionnaire

Welcome to our office! It is well known that families who maintain healthy, properly functioning spines have improved health and long lasting vitality. People whose spines are not functioning correctly are more likely to develop health disorders, immune compromise such as getting sick easier or allergies, pain, low energy, arthritis, and set themselves up for even worse health challenges.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Date of Birth: _____ Social Security #: _____

Mother: _____ Home Phone: _____ Work Phone: _____

Mother Address: Same As Above

Father: _____ Home Phone: _____ Work Phone: _____

Father Address: Same As Above

Siblings Names: _____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____

MAJOR COMPLAINT INFORMATION

What is your reason for contacting us? _____

When did this begin? _____ Yes No – Have you had this before?

What aggravates it? _____ What helps it? _____

Yes No – Does this condition interfere with your sleep? If so, how many times do you wake from pain per night? _____

Yes No – Do any other symptoms accompany this? Please list: _____

Yes No – Have you seen another Doctor for this? Doctors name and specialty: _____

_____ Date consulted: _____ Diagnosis: _____

Yes No – Have you experienced these symptoms before? When? _____

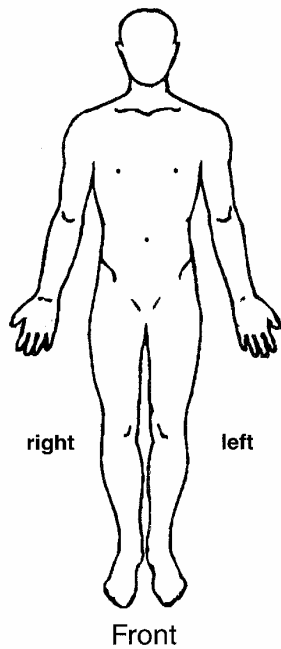
Did this develop from? an auto accident a work injury don't know (chronic) other

CHILDHOOD

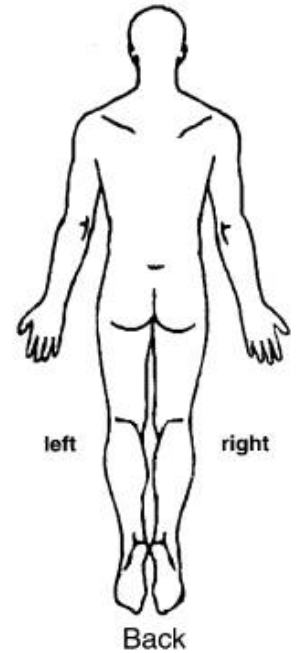
Please check any problems the patient had during childhood:

- | | | |
|--|---|---|
| <input type="checkbox"/> Falls or Injuries | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Allergy/Asthma | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Immunization | <input type="checkbox"/> Extremity or back pain |
| <input type="checkbox"/> Gait problems | <input type="checkbox"/> Antibiotic use | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other: _____ | | |

PLEASE MARK ANY AREAS WHERE SYMPTOMS ARE PRESENT AND DESCRIBE BELOW (type of pain [sharp, dull, achy, throbbing] and the intensity on a 1-10 scale when it is worst, i.e. sharp, shooting – 6):



Description: _____



Yes No – If the doctor feels that chiropractic will help you, are you willing to follow his recommendations?

If there were an affordable way to correct your Child's health problem, would you be willing to do what it takes to accomplish this now? Yes No

I hereby authorize this office and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/Legal Guardian

Date