Jade Chiropractic & Wellness Center

ADOLESCENT INFORMATION FORM (13-17 YRS)

Patient Information

Name:_____Date: _____
Date of birth:_____Age: _____
Parent/Guardian's name(s): _____
Street address: _____
City:_____State:_____Zip code: _____
Home phone:_____Cell phone: _____
Email address: _____
Insurance Provider/ID#: _____
Whom may we thank for referring you? _____

Patient History

How would you describe the pregnancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult How would you describe infancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult How would you describe childhood? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
If you answered anything but normal, why? _____
_____
How would you describe overall physical development?
❑Above average ☐ Typical ☐ Behind schedule
How would you describe overall mental development?
❑Above average ☐ Typical ☐ Behind schedule
Any childhood illnesses/diseases? _____
Any surgeries? _____
Any accidents? _____
Has your child been immunized? Yes/No
If yes, which ones? _____
Reason: ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No
Has your child been on antibiotics? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins? Yes/No
If yes, how often and what purpose? _____
Is there anything significant in patient's health history the Doctor should know?
_____

Health & Wellness

What is the reason for your visit today? □ Wellness Check-–Up □ Other

Other: _____

If other, how long has this been a concern? _____

Is it getting worse? □ Yes □ No □ Not sure

Does it affect activity? □ Not at all □ Somewhat □ Always

Has anything been done already to address this concern? _____

Are any of the following symptoms present?

Stomach pains
Hyperactivity/Autism
Leg/Knee pains
Scoliosis
Learning difficulties
Low energy Asthma
Irritability/Moodiness
Low self-–esteem
Allergies
Growing Pains
Headaches/Migraines
Seizures
Infections
Tonsillitis Diarrhea
Constipation
Sleeping problems
Repeated colds
Digestion
General fatigue
Acne/Skin problems
Depression Menstrual cramps Anxiety
Excessive hunger

Other _____

Do you participate in any athletic extra curricular activities? Yes/No

If yes, which ones? _____

Rate your diet: □ Well-–balanced □ Average □ High sugar/processed foods Do you consume artificial sweeteners? Yes/No

Rate your exercise: □ Frequently □ Sometimes □ Never

How many glasses of water do you drink?_____/day

Number of hours you sleep?_____hours/day

Sleep quality? □ Good □ Fair □ Poor

Rate your general mood: □ Happy □ Melancholy □ Depends on the day

Is there anything else you would like the Doctor to know? _____

_____

Authorization to treat a Minor

I,_____the undersigning parent/guardian having legal custody/ guardianship of_____, a minor, do herby authorize, request, and direct the staff and doctors of Seahurst Chiropractic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's name: _____

Parent/Guardian's signature: _____ Date: _____