Adolescent Intake Paperwork

Name_____Date_____
Insurance:_____ Male Female
Address:_____
Phone# _____
Email_____
Occupation:_____ Employer:_____
Social Security #: _____DOB:_____
Parent Name/Phone:_____
Primary Care Dr_____

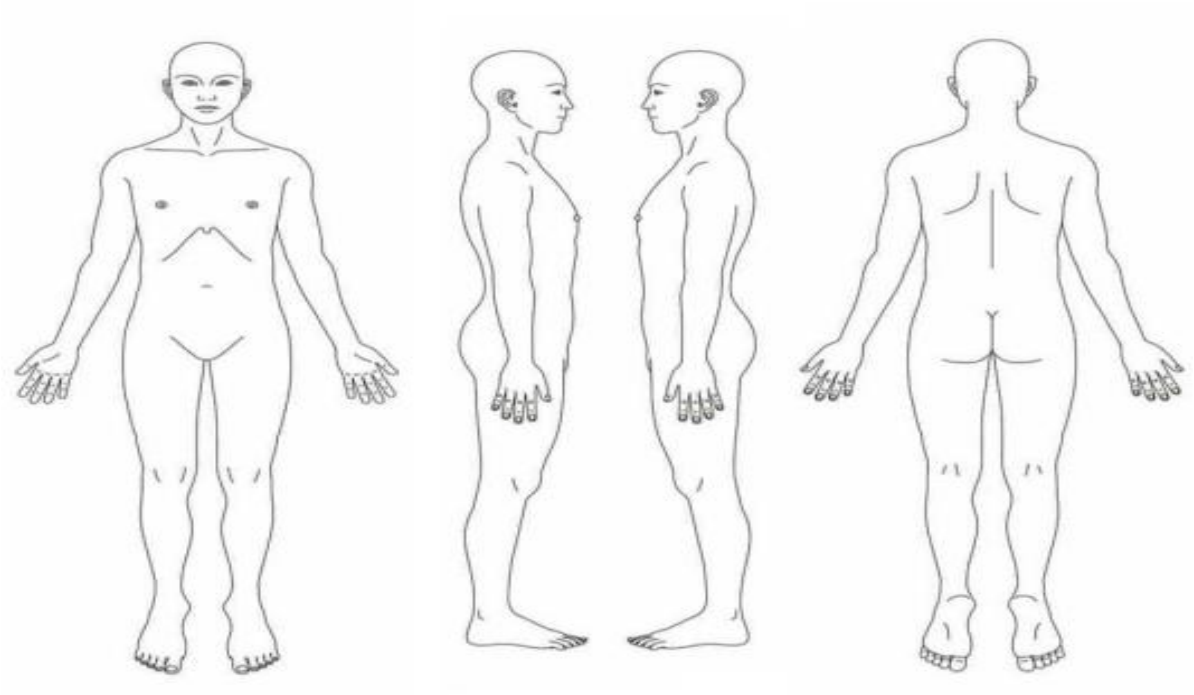
What are your goals you hope to achieve through treatment?_____

How did you hear about us?_____

Chief Complaint: Give a brief description of the problem(s) you are having:_____
_____

Please describe the pain you feel (i.e. burning, aching, stabbing,etc)_____
How often do you experience the pain?_____
When did this condition begin?_____
Is the pain getting Better Worse Staying the same
What seemed to be the initial cause? _____
Does your pain interfere with school, extracurricular or social activities? Yes No

Please mark your area(s) of pain on the figure below



Do you take any vitamins? If yes, what?_____
Do you take any meds? If yes, what?_____
Do you play sports? Yes No
How often?_____
What sports?_____
Do you dance? Yes No
How often?_____
What types of dance?_____
How many hours per day are you on your ipad/phone/laptop?_____
Do you carry your backpack all day or leave it in a locker?_____
How heavy is your backpack?_____
Do you play an instrument?_____
How often and for how long?_____
How often are you carrying your instrument at school?_____
How would you describe your energy level?_____
How would you describe your sleep habits?_____
Have you ever been hospitalized? If yes describe_____
Have you ever been in a car accident? If yes describe_____
Have you ever had a sports injury? If yes describe_____
Do you have issues with constipation or diarrhea?_____
Do you have any allergies? If yes, what?_____

Female Health:
Do you get a period? Yes No Age at which you got your first period_____
Describe your periods_____
Are they regular? Yes No
Are they painful? Yes No
If yes, describe pain and location_____

Sexual Health: Do you have any concerns about your sexual health?_____
Are you or have you ever been a victim of domestic /sexual abuse? Yes No

Mental Health: Do you have any of the following? anxiety ADD/ADHD insomnia depression bipolar mood change behavioral change suicidal thoughts/attempts
Do you have pets? If so, what? _____

Social History: Please indicate none, mild, moderate or heavy
Alcohol
Coffee
Smoking, cigarettes or vape
Drugs, including marijuana
Exercise
Sodas and sugary foods
Salt
Water

Family History: Indicate who had any of the following:
Alcoholism/Substance Abuse
Anemia
Heart Disease
High Blood Pressure
Arthritis
High Cholesterol
Asthma
Multiple Sclerosis
Osteoporosis
Cancer
Stroke
Diabetes
Thyroid Disease
Epilepsy

General Health: Circle any conditions you have had / have:

Alcoholism	Lung disease	Dizziness	Nausea
Arthritis	Lupus	Headaches	Painful Defecation
Anemia	Chronic ear infections	Sinus Infections	Rectal bleeding
Asthma	Deafness	Vertigo	Vomiting
Appendicitis	Double vision	Contacts/glasses	Vomiting blood
Bronchitis	Headaches	Facial weakness	Heart murmur
Cancer	Pleural vision	Limb weakness	Bursitis
Cerebral Palsy	Scoliosis	Stress	Foot trouble
Cold sores	Seizures	Unsteady gait	Muscle weakness
Colitis	Thyroid disease	Loss of balance	Low back pain
Concussion	Ulcers	Abdominal pain	Middle back pain
Kidney disease	Chronic fatigue	Bloody/tarry stool	High back pain
Diabetes	Fainting	Belching	Neck pain
Eczema	Loss of appetite	Chrohns	Sprain/ strain
Epilepsy	Night sweats	Reflux	Fracture
Fibromyalgia	Weight gain/loss	Hernia	IBS
Liver disease	Nervousness	Indigestion	

Informed Consent Statement:

I hereby request and consent to their performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor named below and or with other office/ clinical personel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, dislocations, disc injuries, strokes and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have read to me the above consent. I also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Parent Signature: _____

Doctor Signature:_____

Date:_____