Seeley's Bay Family Chiropractic

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CONFIDENTIAL PATIENT INFORMATION ~ Age 10-16

Name: _____ Date: _____

Phone: Res: _____ Cell: _____

Email: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: (m/d/y) _____ Family Physician: _____

Health Card# _____ Version Code: _____

Who may we Thank for referring you to your office? _____

Your Health Profile

As a full spectrum solution based Chiropractic office. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity to improve you health potential and wellness. On a daily bases we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most time the effects are gradual; not even felt until they become serious.

Family History

Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
1.		
2.		
3.		
4.		

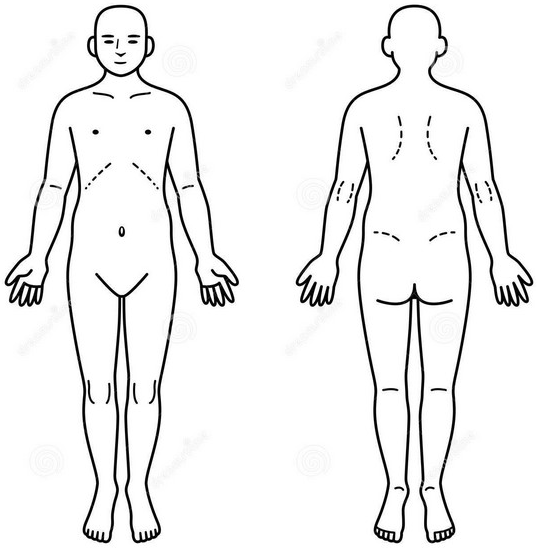
Acknowledgement & Consent

Parent/Guardian (please print): _____

Parent/Guardian Signature: _____ Date: _____

Your Current Concerns

Please describe the locations of your chief complaint using the key. Chiropractic assess the whole body so please indicate all areas of concern, even if you think they are unrelated to your chief concern.
(Eg: Injury, accident, fall, performance, etc)



KEY

Please place letter of the key at your areas of concern.

A-ache
B-burning
N-numbness
P-pins/needles
S-stabbing

Reason for your visit? _____

When did this condition (s) begin? _____

Has it occurred before? _____

How frequent is the complaint? __Constant __Daily __Intermits __Nights Only __Other

Since it began, it is… __About the same __Getting better __Getting worse

What makes it worse? _____

How long does it last? __All Day __A few hours __Minutes Is it… __Mild __Moderate __Severe

Please rate you pain on the scale. No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Is the pain local? Y / N Does it go down your leg / arm? Y / N

What relieves the problem for you? (eg: rest, ice, heat, stretching, medication) _____

How has this impacted your life? _____

What have you had to give up because of this? _____

Growth & Development History

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did/does your child ever suffer from colic, reflux, or constipation? Y / N

Did /do they have any childhood illnesses? Y / N If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, growing pains or bang their head? Y / N

If yes, please explain: _____

Please list any food intolerances or allergies and when they began: _____

_____

Are your child's vaccinations up to date: Y / N Have their been any vaccination reactions: _____

Has your child received any antibiotics? Y / N If yes, how many times and list reason: _____

Night terrors or difficulty sleeping? Y / N If yes, please explain: _____

Behaviour, social or emotional issues? Y / N If yes, please explain: _____

Have teeth been extracted or dental orthodontics used? Y / N

TRAUMAS: Physical Injury History

Y / N Have you ever had any significant falls, fractures, surgeries, hospitalization or other injuries? If yes, please explain. _____

_____

Y / N Any auto accidents? If yes, please explain. _____

_____

Y / N Do you play sports? Type of sport? _____ Frequency?_____

Y / N Have you ever been unconscious? _____

How many hours per day you typically spend on a computer, tablet , phone or watching TV? _____

List any problems with flexibility:

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any medication/supplements you take and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate you stress for each:

	None		Moderate		High		None		Moderate		High
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Health Goals for your Child

What are your top three health for your child?

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

__Resolve existing condition

__Overall wellness

__Both

Have you ever visited a chiropractor? Y / N If yes, what is their name? _____

What is their specialty? __Pain Relief __Physical Therapy/Rehab __Nutrition __Subluxation based

__Other _____