CHIROPRACTIC &
VITALITY STUDIO

TEEN HEALTH HISTORY FORM

Today's Date: ___/___/___

Name: _____

What do you prefer to be called? _____

Parents / Guardian Names: _____

Mailing (Street) Address: _____

City: _____ State: _____ Zip Code: _____

Parent's email address (for office updates): _____

Home Phone: _____ Mobile Phone: _____ Parent's Mobile Phone: _____

Birth Date: ___/_____/_____ Age: _____ Sex: M___ F___

How did you learn about our office? _____

Previous chiropractic care? Yes_____ No_____ Approximate last visit date: _____

Hobbies: _____

Do you have health insurance? Yes _____ No _____

Please check your reasons pursuing chiropractic care:

___ I'm continuing ongoing care from another chiropractor.

___ I'm Interested in wellness and natural health care.

___ I'm concerned about my health and I'm looking for answers.

___ I have a specific condition that concerns me.
Explain condition or symptom: _____

___ I want to improve my immune function.

___ I have no idea why I'm here. Please take the time to explain to me what you do.

Please check any of the following body signals/conditions you have experienced within the past year:

Dizziness or Fainting___ Headache___ Poor Posture___ Arthritis___ Asthma __ Short Leg/Orthotics___

Ear Infection___ Intestinal Problems___ Frequent Colds___ Sinus Problems___ High Blood Pressure___

Bladder Problems___ Lyme Disease___ Scoliosis___ PMS___ Menopausal Symptoms___ Infertility___

Thyroid disease___ Cancer___ Diabetes___ Alcoholism___ Stroke___ Multiple Sclerosis___ Ulcers___

Other: _____

Medical History

Known food allergies or intolerances? No___ Yes___ List: _____

List high impact or contact type sports has you have been involved in over the years? (i.e. soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts)?

_____

_____

Have you been seen on an emergency basis? No___ Yes___ List: _____

Prior surgery? No___ Yes___ List: _____

How much time does you spend time using electronics (laptop, iPad, video games, cell phone)?

_____ hours per day (approximately)

List prescription or over-the-counter medications you are currently taking:

_____

Known allergies: _____

_____

(CONTINUED)

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation). Which of these stresses do you recognize? Please circle when you experienced these stresses may have happened:

Physical/Emotional/Chemical Stress	Child	Teen	Comments
Slips/Falls	C	T	
Car Accidents	C	T	
Sports Injuries	C	T	
Physical Abuse	C	T	
Poor Posture	C	T	
Carrying Heavy Purse/Bookbag		T	
Continuous Hours Sitting/Standing		T	
Relationship Stress	C	T	
Concealed Feelings	C	T	
Quick Tempered	C	T	
Smoker/Second Hand Smoke	C	T	Amount: _____
Poor Diet/Excessive Sugar	C	T	
Artificial Sweeteners	C	T	
Over-The-Counter Drugs (ex. Tylenol, Motrin)	C	T	

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

X _____ _____/_____/_____

(Parent / Guardian Signature) (Date)