Chiropractic Case History | Ages 12 – 17

Date:_____

Name: _____ Phone _____ Home/Cell

Address: _____ City: _____ State:_____ Zip: _____

Birth Date: _____ Age: _____ Email Address: _____

Mother's Name:_____ Father's Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Number of Siblings: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes/No

(fill out the following if applicable)

Occupation: _____ Employer: _____

Phone: _____ Address: _____

History of Present and Past Illness:

Chief Complaint/Purpose of this appointment: _____

Date symptoms appeared or accident happened:_____

Is this due to: Auto ___ Sports ____ Other _____

Have you ever had the same or a similar condition? Yes/No

If yes, when and describe:_____

Date of last physical examination: _____ Date of last dental exam: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents, surgeries?

_____

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Patient Name: _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

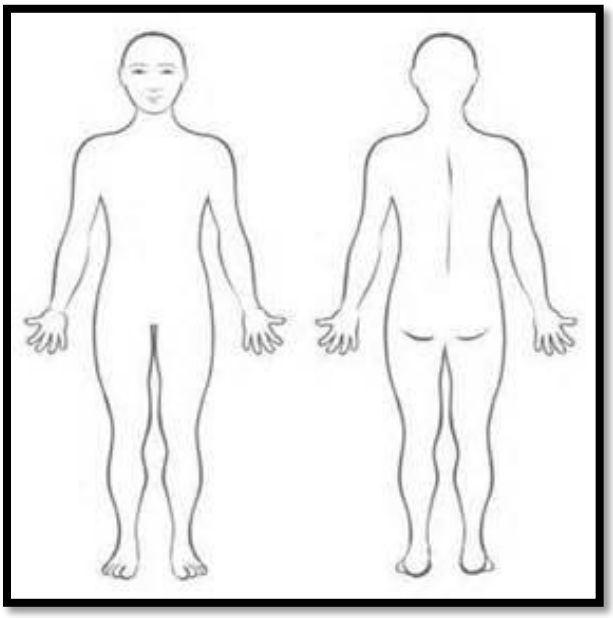
Do you have any allergies to any medications? _____

Do you have allergies of any kind? _____

Do you have any congenital condition? _____

Are you pregnant? Yes No

Mark the areas of pain/ symptoms with an **X**



Are you currently taking any vitamins or supplements? YES/ NO
If yes, please list here: _____
_____

How would you rate your diet?
Fair Poor Good Excellent

How would you rate your overall health?
Fair Poor Good Excellent

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you had these conditions **previously.**

Headaches	_____	Frequency _____	Numbness in fingers/toes	_____	
Neck Pain	_____		High Blood Pressure	_____	
Stiff Neck	_____		Loss of Balance	_____	
Sleeping Problems	_____		Fainting	_____	
Back Pain	_____		Bed wetting	_____	
Nervousness	_____		Ear Infections	_____	
Tension	_____		Asthma	_____	
Irritability	_____		Feet Cold	_____	
Chest Pains/Tightness	_____		Hands Cold	_____	
Dizziness	_____		ADD/ADHD	_____	
Shoulder/Neck/Arm Pain	_____		Muscle Spasms	_____	
Frequent Colds	_____		Sinus Problems	_____	
Kidney Problems	_____		Diabetes	_____	
			Stomach Aches	_____	

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Weakness in Extremities	_____	Menstrual Difficulties	_____
Difficulty urinating	_____	Joint Pain/Swelling	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Autism	_____	Seizures/Epilepsy	_____
Excessive Bleeding/Anemia	_____	Low Blood Pressure	_____
Scoliosis	_____	Growing pains	_____
Walking trouble	_____	Heart Problems	_____
Stroke	_____	Cancer	_____
Ruptures/ Hernia	_____	Coughing Blood	_____
Eating Disorder	_____	Diarrhea	_____
Digestive Problems	_____	HIV Positive	_____
Gall Bladder Problems	_____	Constipation	_____
Ulcers	_____	Behavioral Problems	_____

Other: _____

Any significant family history the doctor should be aware of? Yes/ No If yes, please explain: _____

_____

Social History

Please indicate beside each activity whether you engage in it:

Often = O Sometimes = S Never = N

_____ Vigorous Exercise
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ Tobacco Use
_____ Caffeine
_____ High Stress Activity

_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stress
_____ Other (specify)
_____
_____

What are 3 things that you are currently unable to do which you would like to be able to do? _____

_____

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Legal Guardian _____

Date _____