Castle Hills Chiropractic
Bringing Wellness to Our World

Age 6 - 18

Name:	Date of Birth: Sex: Male Female
Mailing Address:	Parent/Guardian Names & Phone Numbers:
Phone Number with Area Code:	E-Mail:
Hobbies & Sports you enjoy:	Family Medical Doctor:
Referred by: please list person's name ○ Friend/Family ○ M.D. / D.C. ○ Internet/Add	
Have you had chiropractic care before? If so, when and by whom?	

Healing Source Chiropractic focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible chiropractic care, we will need to discover any **stresses** that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting Healing Source Chiropractic: ○ Wellness / Prevention Care - I wish to continue my chiropractic wellness care.

○ A current problem

Please describe your current problem, including the effect it has had on your life:

_____

_____

_____

_____

_____

Please describe the character of your pain, check all that apply:

Sharp/Stabbing	Sharp/Dull	Achy	Dull	Soreness	Weakness
Throbbing/Gnawing	Numbness	Shooting	Gripping/Constricting		
Burning	Tingling	Other_____			

How bad is your pain or ache?

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

How often are the complaints present?

○ Constant: 76-100% ○ Frequent: 51-75% ○ Occasional: 26-50% ○ Intermittent: 25% or less

When is the pain or symptom worse?

○ When you wake up ○ During the day ○ After work ○ In the evening ○ After eating ○ While sleeping

Since your problem began is the pain: ○ increasing ○ decreasing ○ not changing

When did your problem begin?_____(specific date of possible)

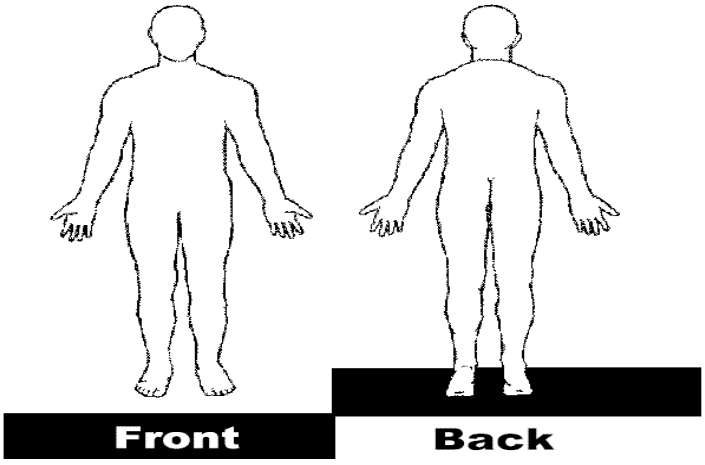
Do you sleep on your: ○ Back ○ Stomach ○ Left Side ○ Right Side

Physical activity at work: ○ sitting more than 50% ○ Light manual labor ○ Heavy manual labor

General physical activity: ○ No regular exercise program ○ Light exercise program ○ Strenuous exercise program

Rate your stress level: ○ No stress ○ Minimal stress ○ Moderate stress ○ Greatly stressed

Draw on the diagram where you feel your symptoms



Do you currently smoke? Yes No if YES how many packs a day:_____ Number of years:_____

Describe any falls, auto accidents or major injuries - include month & year and type of accident:_____

_____

_____

Describe all past surgeries:_____

_____

List ALL medication that you are currently taking – prescription and over the counter:_____

_____

Personal History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke Heart Condition Hypertension Polio Asthma Psoriasis. Other:_____

Family History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke Heart Condition Hypertension Polio Asthma Psoriasis. Other:_____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem:

○ Headaches/Migraines	○ Buzzing/Ringing in Ears	○ Lungs	○ Low Back Pain
○ Dizziness	○ Fatigue	○ Heart	○ Hip Pain
○ Eyes/Vision	○ Fainting	○ Stomach	○ Leg Pain/Cramps
○ Concentration Loss	○ Sinus	○ Indigestion	○ Poor Circulation
○ Depression	○ Neck Pain/Stiffness	○ Bladder	○ Numb Felling
○ Nervousness	○ Feeling of Pins/Needles	○ Liver	○ Shoulder
○ Sleeping	○ Upper Back	○ Colon	○ Hot Flashes
○ Loss of Energy	○ Mid Back	○ Kidney	○ Cold Sweats
○ Tired Mornings	○ Chest Pain	○ Constipation	○ Diarrhea
○ Loss of Taste/Smell	○ Menstrual Pain/Irregularity	○ Urination	○ Fever

Do you drink bottled or filtered water: Yes No

How much water do you drink in a day?_____

How many servings of fruit and vegetables do you eat on a typical day?_____

If you remember the detail, what was your birth delivery like – breach, C-section, long:_____

Have you had any or all of your childhood vaccinations?_____

Did you have any reactions to vaccinations? Yes No

Please list all supplements and vitamins you take:_____

How many hours a day do you spend in front of: _____computer _____tv _____gaming

How many hours a day to you exercise?_____

How would you rate your health:

1 2 3 4 5 6 7 8 9 10
I have never felt worse I feel great!

What is your goal or expectation with chiropractic care?_____

_____

I hereby authorize the doctor to examine and treat my condition as deemed appropriate through the use of chiropractic care and I give authority for these procedures to be performed. I have been informed of the financial policy and agree that I am responsible for all expenses incurred at Healing Source Chiropractic. I have had an opportunity to review the privacy policy and agree to its terms.

Patient Name (printed):_____

Parent/Guardian Name (printed):_____

Parent/Guardian Signature:_____ Date:_____